PUBLIC HEALTH NURSING

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THE NEW BOARD MEMBERS' MANUAL

WITH the multiplication of public health nursing agencies and the increasing complexity of their programs, the responsibilities of boards and committees have constantly increased. This has been true in the whole field of health and social welfare. In an article in this magazine, Arthur Dunham describes the qualifications of a modern board member and points out the serious obligation which is his. (Page 629.) Certainly a sound community program today is contingent upon an informed board of directors who have studied the work of the agency in relation to community needs and who know whether their community is getting the best possible service for its money. As the president of a welfare federation recently expressed it, "I do not believe that any layman should allow himself to be a member of a board if he does not know enough about the subject matter of the agency's work to precipitate an occasional controversy."*

*Griswold, H. H. "What Can the Layman Do?" An unpublished address presented before the National Committee of Volunteers in Social Work, Indianapolis, Indiana, May 26, 1937.

The same writer emphasizes the importance of a definite program of training and instruction for all lay participants. "It should not be necessary," he says, "for a layman to attend board meetings for a year before he knows what it is all about." It was precisely with this need in mind that the *Board Members' Manual* was prepared by The National Organization for Public Health Nursing in 1931. Professional workers had long used manuals to guide them in their work. Why should not the board member, who is responsible for securing the best possible professional service for his community, also have the benefit of such a source of information? Since the first edition of the N.O.P.H.N. manual appeared, several such handbooks have been developed for board members in other types of social and health agencies.

We have learned a great deal since the first manual was published in 1931, and there have been certain changes in public health nursing administration. Chief of these has been the trend toward the administration of public health nursing under official agencies, accelerated by the additional funds made

available under the Social Security Act. The need for an informed lay group in the community has not decreased, however. On the contrary! The perpetuation of public services depends upon the renewal of appropriations, which in turn is contingent on the interest of an enlightened public. High standards of public service will depend upon the demands of an intelligent lay group. Citizens' advisory committees have been organized in many places to serve as a means of interpretation of the agency to the community, and community needs to the agency.

This and other new developments in the field have made necessary the complete rewriting of the old manual, and the revised book has just been published. (See page 669.) It is hoped and believed that the new manual will be a valuable guide for the education of board members—old and new—and that boards will be able to study their own organizations in the light of the suggestions it contains. Although it is written primarily for board members, the manual is equally of value to the public health nursing executive, and also to the nurse working alone in a county, who may want to organize a lay advisory committee. P.P.

UNDER THE RED CROSS EMBLEM

AT THIS SEASON, when the Red Cross again enrolls the American people under its emblem, it is appropriate to recall that some of our most important health programs and activities have been developed by the American National Red Cross.

Today public health nursing is carried on in rural areas in every state in the country. Under the Social Security Act it is reaching areas which could never before afford a nurse. It is one of the most challenging, picturesque, and at the same time heroic fields of endeavor in nursing. But who developed rural nursing in this country? It was the Red Cross Town and County Nursing Service which pioneered in 1912 and set the pattern. It was again under the Red Cross that rural nursing was enormously stimulated during and after the World War; that itinerant services to isolated rural areas have been and are made possible. It is under the Red Cross banner that many nurses are still carrying on regular community nursing services in rural areas today.

Today the teaching of health in classes, clubs, and various groups of all ages is accepted as an economical and effective method of carrying on health education in the community. But who pioneered in this activity, experimented with it, and popularized it throughout the length and breadth of the land? It was the Red Cross, whose classes in Home Hygiene and Care of the Sick were also started in 1912 and are still carried on as one of the organization's outstanding activities.

Accident prevention, first aid, and safety in the water are now important parts of industrial and school programs. Besides the far-flung Red Cross program in safety education and succor through first aid stations, many other organizations are carrying on safety programs. But the leadership of the Red Cross has been a guiding star in arousing public opinion, developing popular education, and setting the standards for safety.

The past winter brought to the Ohio and Mississippi valleys the greatest midwinter flood in a quarter of a century. Federal, state, and local agencies coöperated in the rescue and rehabilitation work. The Red Cross, with its experience in 2000 disasters, became the channel through which the American people administered over $25,000,000 in relief to the victims. Its experience, its machinery for disaster work, and its effective organization of local disaster programs stand as an insurance for the protection of every community today.

Public Health Nursing Marches On

By THOMAS PARRAN, M.D.
Surgeon General, United States Public Health Service, Washington, D. C.

We need more nurses and health officers who can organize the resources of the community against today's dangers, not yesterday's, says Dr. Parran

ALWAYS it is pleasant to look backward when one has gone far. I think that most of you who have been here tonight for the N.O.P.H.N. birthday party know in rather intimate detail how greatly the scope of public health nursing has been enlarged since the birth of this organization 25 years ago. You know, too, how greatly the numbers of public health nurses have been expanded. By this year's count, we have 17,615 nurses doing public health work, which is a gain of 1700, or more than 10 percent, over the number employed in 1931;* and very much greater than in 1932 and 1933 when the bottom dropped out of public health budgets. I think, also, you are keenly aware that in this country more than any other—with the possible exception of Canada—there is almost complete recognition among health officers and citizens alike of nursing as the spearhead of the whole public health movement. Dependence is placed upon it to advance new causes and to serve new needs. These things have been accomplished in the days of your youth and young adulthood as an organization. Of them we need not speak.

In spite of the fact that public health nurses only recently became a part of the Public Health Service, the problems which confront you are an integral part of our problems, nationally and in the states and the communities. Frequently in the past and even now in some sections of the country, the problem has been quantitative. For there are many situations in which any public health nurse is better than no nurse. Increasingly, of course, the problems have become qualitative. It is a never-ending fight to make sure that the new nurse for the job is qualified; that the new job for the nurse requires qualifications; and that the nurse who has evolved on the job shall have proper opportunity to grow mentally and to acquire proven techniques.

Among nurses as among health officers, however, I am sure that you have shared our distress at the repetition of episodes where technical qualifications are not enough. It takes more to make a good health officer than an M.D.—some years of apprenticeship, and a public health course in one of the several universities which offer sound postgraduate training. It takes more to make a good public health nurse than an R.N.—some years of nursing, and a public health nursing course in one of 17 schools which offer sound postgraduate courses. When we have learned the intangible *what* and *why* which separates the efficient from the futile (among those with similar technical backgrounds) we shall have learned the basic lesson in personnel management—or vocational adjustment, call it what

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Presented at the N.O.P.H.N. Silver Jubilee Dinner, Pennsylvania Hotel, New York, N. Y., October 4, 1937.

*See "Census of Public Health Nurses 1937," page 648.

you will—which needs to be learned promptly. For without able administrators and executors of sound public health policy, without a considerable addition to the ranks of those who can both interpret and create, without adding year by year to the ranks of those qualified for leadership, I see the probability of a levelling-out in public health accomplishment.

SELECT POINTS OF EMPHASIS

Even now we find many a community where the major health emphasis seems to be upon the minor plagues. Except in a few areas the diseases of environmental insanitation are well behind us. The task of immunization grows steadily less difficult. We need more nurses and more health officers who are realists; who can organize the resources of the community against today's dangers, not yesterday's. It cannot too often be reiterated that we must hold fast that ground that we have gained, but make the greatest *new* effort where the greatest saving in lives can be made. From the strictly professional point of view, this is sound policy for nurses. Until scientific research produces new knowledge for death-fighters to use, syphilis, tuberculosis, cancer, pneumonia, infant mortality, maternal mortality—these are the sectors where the saving of life can be greatest. The attack against them must be vigorous. It should make far more use of nurses than any health campaign has done in the past.

The program against tuberculosis was, of course, the first to be organized on a national scale; the first to use the three-horse team of doctor, nurse, and citizen. But as I go about over the forty-eight states and see the unevenness of effort and of results, the utter lack in whole states of facilities to find and treat tuberculosis, the time and money wasted in arresting active cases by sanatorium treatment when so frequently the patient goes back to the old trade, the old environment, and the final, fatal breakdown; above all, when I see the listlessness with which we have approached the whole problem of tuberculosis in the Negro—I begin to think the time is ripe, if not for a reorganization, at least for a reorientation of the national tuberculosis attack. We need among all the states the steadier alignment and firmer integration of the official and voluntary agencies which a few states have achieved. We need new force—new driving power. We need to hitch up our "galluses" for a last, long lift at the burden. For the end is in sight. This is another plague we can set behind us, if we will. We have been congratulating ourselves because it has been driven down six places among the causes of death. Let's drop it into the subcellar with typhus and yellow fever which to this nation have become insignificant. We can be rid of tuberculosis. We must be rid of tuberculosis. But the public health nurse must bear the brunt of the battle.

REDUCE MATERNAL AND INFANT DEATHS

Though great reductions have been made, we have always with us the needless deaths of infants and of mothers in childbirth. When the good care which some mothers and children have is available to all; when we educate mothers to know what good care is, to know who is qualified to give it, and to require it for themselves and their babies, we shall be able to cut the present death rate by at least a half. What savings have been made have been largely through what the nurse has accomplished for us. What savings can be made are within her gift. Here, as in other victories to be celebrated tomorrow, the public health nurse must bear the brunt of the battle.

The national effort against cancer, as you know, is just beginning to take form and substance. When I appointed an Advisory Committee to counsel with us on new programs, I found that some of

the busiest men of the nation—the most significant of the men of science—were glad to serve on it. There is wide interest in the provision of facilities for diagnosis and treatment, as well as for cancer research. With the leadership of Massachusetts and New York, the states are beginning to realize their responsibility for stemming the flood of needless deaths. There are still enough cancer cases for whom we can do nothing. For others we can do much. It is a moral obligation to save those whom we know how to save. We can do this if we find the patient early and give him expert treatment. To do this, we must have the courage and imagination of the well trained nurse who will bear the brunt of the battle.

Like cancer, the national fight against syphilis is in a formative stage. The task has barely begun in any state or community. We still are tremendously self-conscious about syphilis. We use up so much courage in conversational outlets that there is little left to energize the practical activities of finding cases and giving them treatment, looking for sources, and making the determined effort to keep all cases under treatment until cured or harmless.

THE CLINIC "ASSEMBLY LINE"

I emphasize *good* treatment. During the last month, I visited a city not many hundred miles away where they are giving a great deal more treatment than at this time last year. I visited one clinic in which three doctors and a nurse gave treatments and handled records of almost 300 men and women in a two-hour session. Here stood this weary line of men and women sick with syphilis, packed tightly in two little hot rooms, inching along from table to table for the card record, the shot of arsphenamine, the injection of bismuth. Some of them had been waiting there long hours in order to be sure of a place far enough up in the line to get treatment that day. None of them had an opportunity to report symptoms on reactions to the doctor; none of them seemed to be differentiated from any other by the doctor. Usually he did not even look up when the patient slid the card on the desk or presented an arm for intravenous treatment. How could he look up and ask questions? This was the medical equivalent of a factory assembly line. "Move 'em along," was the one order of the day.

I suppose that sort of thing does some good. I don't know. I don't believe they knew. Similar scenes are familiar to all of you who do active field work. I mention it only to illustrate what, to my mind, is one of the chief dangers ahead for the whole syphilis program; and that is the prevalent idea that clinics of their very nature cannot give good medical treatment and need not give considerate treatment. The thrifty Swedes and Danes can show us that if we give any thought whatever to the relationship between cost and results, it is far cheaper to give good treatment to the individual than to run a heterogeneous mass of individuals through a nondescript treatment mill. The individualistic British will tell us that personalized treatment, scrupulously sanitary and considerate of the privilege of privacy, will go a long way to save us time in searching out new cases and prevailing upon old ones to remain under treatment.

Unless there is a vast transformation in our present methods of bringing together those who can supply medical and nursing care and those who need it, I see no other method than the clinic by which we can afford to supply from public or private funds the minimum of a year's treatments, costly drugs, and laboratory services to those sick of syphilis among the third of our population who are ill fed, ill clothed and ill housed. But I think I am not far wrong when I say that many of the syphilis clinics as now constituted are unfair to doctor,

nurse, and patient, and benefit the patient but slightly. The few which are organized to supply good service are not sufficient to leaven the lump. No group sees so much of the wrong sort of clinic as do nurses. I know of no place in public health where the community nurse and the nurse social worker count so much as in the community protection against syphilis. We need the vision and the persistence of the well trained nurse to build a better program. She must bear the brunt of the battle.

CHALLENGE OF PNEUMONIA

For pneumonia control, the pot is just beginning to simmer. Again, New York and Massachusetts have led the way by initiating public support of the private physician in his year-in, year-out struggle with this most feared of human foes. At the present level of medical knowledge about pneumonia, I think it is agreed that our hope of reducing it lies in two things: first, prompt diagnosis, and administration of serum for all cases it will benefit; and second, good nursing for all cases. During these last years, the clinical authorities have proven beyond shadow of a doubt, through evidence laboriously accumulated over the years and meticulously weighed in the balance, that the great scourge of pneumonia can be alleviated. It is only by the fullest exploitation of what we can do that we shall learn how to do more, how to be rid of it—as we know now how to be rid of tuberculosis as a public health problem if only we were to pursue to the fullest the methods we know. Here, as in all public health crusades, the nurse must bear the brunt of the battle.

One still occasionally finds those who inquire whether it is not poor policy to think of public health programs in terms of attacks-on-disease categories. If we set our three-horse team of doctor, nurse, and citizen to pulling the deadweight of syphilis, what will become of our school health program? If we put our community nurses to the care of pneumonia, how are we going to get our preschool children immunized against diphtheria?

I think that by the exercise of a moderate degree of common sense we can incorporate with the continued protective controls for the community a new and earnest effort against the plagues which now decimate its population. The introduction of the principle of the generalized service, in my opinion, was as important to public health nursing as the introduction of radium into the treatment of cancer. Both opened up magnificent opportunities for service which have been only partially explored. The Children's Bureau used a provocative slogan in a controversy some years back. They pleaded that we should not "dismember the child." I need not do special pleading before this audience, for I know your organization to be unanimously in favor of a generalized program. But certainly we must make the citizen members, and sometimes the doctors in our public health team, understand that the family health program must not be dismembered by a series of specialists each attacking as separate problems school health, infant welfare, tuberculosis, communicable disease, nutrition, bedside care, and a dozen matters which are of importance to the well-being of the family as a unit. Moreover, I believe we could go farther than most generalized programs have gone; that we could and should wipe out the lines of demarcation between the public health nurses who restrict themselves rigidly to conversation and demonstration and the visiting nurses who care for the sick and attempt to educate by example as well as by precept. It seems to me that a next and needed step is for health departments to provide community nurses who will have responsibility both for prevention and for bedside care, as needed. I say health departments, because the present visiting nurse organizations are, for the

great part, confined to the cities. In the rural areas I see no way by which these needed services can be given except through public funds.

Further, almost one-half of present health department budgets already are expended for public health nurses. We are agreed that we need more good nurses, many more. We are likewise agreed that the health departments themselves need larger and better budgets if they are to do even a fair job in disease control. I think we need to face the fact, however, that appropriating bodies, politics aside, are generous to concrete services and little impressed by theoretical benefits. Public health nurses had their beginnings in the care of the sick poor. In many places nowadays they have swung so far in the opposite direction that they are of no earthly use to the sick poor. Suppose we get back to the middle of the road and combine both the concrete and the educational functions of a nurse in one valuable person. I think you would find it easier to get more nurses where we need them, and to carry the lamp of public health nursing into the dark places. Suppose, too, we detour the nursing specialists from direct work with the family and gently but firmly keep them in their useful place as consultants to the community nurse. I firmly believe that not only the quantitative but the qualitative aspects of public health nursing, both the scope and the impetus of the whole public health movement, would gain greatly by the simple expedient of following through consistently on the whole principle of the generalized nursing service. Let the public health or rather the community nurse be the answer to St. Paul's exhortation of "all things to all men." It is a large order, but she has filled large orders before and done it nobly.

Public health is a new specialty of medicine and nursing. As in all specialties, when the first excitement of acquiring new knowledge has passed, we begin developing new techniques for its application. Sometimes, both to doctors and nurses, the techniques begin to assume undue importance. They tend somewhat to obscure the human factors. We become detached, formalistic. We lose our hold upon the popular imagination. We lose awareness of our real function which has to do with life and death, and especially life.

I think in some places and among some very skillful workers this has been true of both public health medicine and public health nursing. We have, in some cases, standardized too soon. We have become content with 1930 or 1935 or 1937 models. We who are born of change, who came into the world to uproot the precedents of misery—we fear change, cling to precedent.

FEARLESS LEADERSHIP NEEDED

It is not that we do not think we are doing everything to gain popular support. During the last decade our techniques have included salesmanship. May I be forgiven for saying that sometimes it is too suave, too tactful, too self-conscious for effective functioning? I would only remind you that among the reasons why the light from the lamp of Florence Nightingale shone far was because she was known to be perfectly ready to throw it at anybody who stood in the way of righteous progress. She is remembered for the good works of a saint, but she achieved those good works because she had a clear eye, a pungent tongue, and a heart so filled with wrath at needless suffering that she spared no one, no matter how highly placed, who might be responsible for it. Individually, there are few of us who can be Florence Nightingales. Our little voices would be lost in the contemporary din. Compositely, through the organizations which represent us, we can all have part in leadership. If we lead fearlessly, our good works also, will be remembered.

Just one more word. During this year and in the years immediately ahead

it seems inevitable that public health will be competing for a larger share of smaller budgets with many very worthy projects in the cause of human welfare. Decent housing, better schools, better recreational facilities, more and more intelligent assistance for the aged, the unemployed, and the handicapped—these and other social advances are much needed. We would not retard them. They have deep human appeal. But as Paul DeKruif has said, none of these hears the cry of the meningitic child. We hear that cry; we hear daily the cries of agony we know how to relieve and prevent. We must help our citizen partner to hear that cry. He must share our faith that nothing in life can come ahead of the relief and prevention of human agony.

This is simple to say and hard to do. We must do it, for therein lies the whole of our educational function. One way is to make the citizen a partner in a real sense of the word—not just a lay member whose function is to raise money to get more members to raise more money. Money is important. The most competent health officer, the most skillful and devoted nurse—none of them can fight disease without money, any more than Napoleon himself could fight a battle without bullets. Money is important, but citizen partnership is more important. And service to human beings is most important of all.

WORLD FEDERATION OF EDUCATION ASSOCIATIONS

Seventh Biennial Conference of the Health Section

Leaders in health and education who are concerned with promoting health through the schools of the world, met at Tokyo, Japan, August 1937, in the Seventh Biennial Conference of the Health Section, World Federation of Education Associations. They came from 19 countries—347 of them—and for five days discussed problems inherent in efforts to advance the health of children. All phases of health services, health education, and physical education were presented, in thirty-five papers.

The resolutions adopted reasserted the belief of the group in the value of health promotion through schools. The following aspects of the subject were reaffirmed as representing distinct needs:

That adequate and uniform records of physical examinations for school and college students are desirable.

That content and method of such examinations be determined by competent authorities in each country.

That teacher training include adequate instruction in modern methods of teaching health and in actual coöperation with public health, community, and home agencies.

That recreational and physical activities of children be determined and regulated by adequate medical examinations.

That the program of the Junior Red Cross be utilized as fully as possible in the field of health education and health services.

The Secretariat of the Health Section, 200 Fifth Avenue, New York, New York, will continue to assemble reports on health problems in the various countries, together with methods used in solving these problems and the results obtained by such methods as they affect the school program and the health of children. The officers elected to serve for the next two years are:

Chairman: Clair E. Turner, Dr.P.H., U.S.A.
Vice-Chairmen: Dr. Y. Yoshida, Japan; Dr. R. H. Hazemann, France
Executive Secretary: Sally Lucas Jean, R.N.
Treasurer: R. J. Faust, Jr.

Also, a Section Council of 14 members from 14 countries was appointed to serve for varying terms.

Habit Training During the Preschool Years

By RUTH STEIDINGER*
Merrill-Palmer School, Detroit, Michigan

The preschool child is more pliable and flexible than he will be later. This period is therefore the time in which to build necessary habits for healthful living

IF SUSAN, at six years of age, will be expected to sit up straight while eating a meal, she should not be encouraged, at three, to lean forward over her plate to avoid spilling. It is much better to let her spill on a napkin, tucked in at the neck, as she learns how to sit properly at the table. This is one example of the fact that it is much easier if the child learns, from the beginning, the acceptable thing to do, since it is much more difficult to break down an established habit and build anew. There are the exceptions, of course, when it is necessary to learn and then unlearn. Due to poor motor skills and lack of coördination, an eighteen-months-old child will, naturally, be given a spoon to eat with before a fork is introduced. It means learning to eat first with a spoon, and later with a fork. But such situations are in the minority, and where they exist, should be realized by the adult and handled accordingly.

Habit formation, as one aspect of preschool education, has been variously described and defined. The term will be used here with reference only to those learnings which are to be routinized and fixed. Eating, sleeping, eliminating, dressing, and washing are the processes most frequently included under habit formation, and are often referred to as basic habits. Although there are many other habits, desirable and undesirable, this discussion will be limited to these five habits, since they are of primary importance during early childhood. It is to be remembered that in many learning situations the individual should not react in a stereotyped, crystallized manner, and consequently, it is necessary to realize and appreciate the limitations as well as the benefits to be derived through habit training.

There is no more frequently discussed phase of child guidance than that of habit training. It may appear to some people that the topic has been unduly stressed. However, if each adult were aware of the extent and rapidity with which learning takes place during the early years of life, the problem would no longer appear in exaggerated proportions. Whether or not there is planned guidance, learning is taking place. It means, then, that children will either be learning without direction, often inefficiently, and frequently the wrong thing, or else they may be learning under adequate supervision, building helpful and desirable skills and attitudes which may be enlarged and varied to meet changing requirements in the future. It is easier for both parent and child when the adult has put forth the initial effort of planning a habit program and carrying it through.

In addition to helping the child learn acceptable modes of behavior, the adult should understand the growth of a child sufficiently to realize that during the preschool years he is much more pli-

*In addition to extensive experience in nursery school teaching, Miss Steidinger is familiar with the problems of nurses, having given a course to nurses in the Nursing Education Department at Wayne University in Detroit, Michigan.

able and flexible than he will be later. It is rather like molding a piece of clay. Each touch of the finger leaves an imprint, but as the clay hardens, it grows increasingly more difficult to produce the desired effect. So it is with human beings. We gradually crystallize, and in some cases even let habits make slaves of us. Although flexibility should be preserved to some degree, it should also be used during these early years as a basis on which to build necessary habits for healthful living.

AIMS OF HABIT FORMATION

In setting up aims to be achieved through basic habits, such items might be included as efficiency, social conformity, independence and self-reliance, and health.

1. *Efficiency*

As an illustration of the first of these aims as it might function, visualize the three-year-old who is lacing shoes and needs to concentrate intently on the task. The lacing is usually picked up clumsily. The eyelet is sought for—often the wrong one is used—and then with much effort the tip is inserted and pulled through. Whereas the adult may be planning the day's activities while the dressing process is under way. Through habit formation the child will learn to perform the task with less expenditure of effort and also with less expenditure of time. In like manner, this aim could be applied to the other routines of a child's life.

2. *Social conformity*

With social conformity, the second goal, it is readily understandable how much it helps to be habitually adjusted to the culture of the social group in which one functions. If the child learns early to eat a variety of foods, he is spared the embarrassment of suffering through a meal of disliked foods when he is invited out at a later age.

3. *Independence*

Since each individual, although always dependent to some degree on others, should achieve a relative amount of self-reliance and responsibility, there is no better time to start than during the preschool years. When the five-year-old enters kindergarten he should leave his mother willingly. He should be self-sufficient in dressing habits, including wraps. The same is true of elimination and washing. If he is to care for his own physical needs by this age it necessarily means preparation during the preceding years.

4. *Health*

With reference to health, bodily rhythms in eating, sleeping, and eliminating need to be regulated and established in order to achieve a state of well-being in an individual. Again, the time of life when these are laid down should be between birth and school age. Adjustments will be necessary to care for changing needs, such as decreased quantity of sleep; but once the habits are formed, readjustments should follow with comparative ease.

Regardless of the learning situation—whether it be any of the five mentioned habits here under discussion or other phases of learning—the adult who is to approach the child guidance problem intelligently should ask herself these questions:

1. What should the child be learning for his best development both now and in the future?
2. How can I, as an adult, give him the help he may need?
3. What is it he is learning, and how satisfactorily is he learning what he should be?

Even before these questions are asked it is assumed that the adult should know, in general, what the average child can be expected to do at different age-levels. Then, with this concept of average expectations, it is possible to move a step further and evaluate each indi-

vidual child in relation to group norms in order to keep a perspective on his total development and also to recognize and correct possible deviations. It is necessary, however, when comparing a child with the average to consider his capacity for development as well as his past opportunities. Never is it legitimate or fair to the individuals concerned to compare one child with another. The comparison should be made in relation to group norms.

It becomes necessary, then, to sketch a brief survey of the levels through which children pass during the preschool years in the acquisition of basic habits. It should be remembered that in the process of growing up, all children will have difficulties and problems, and that adults should caution against labelling a girl or a boy as a problem child. What may be a behavior problem at one age, may be the typical reaction at another.

It might help, in the field of habit training, to discuss each specific habit from these two approaches: the normal expectation, and the frequently occurring difficulties. They will be taken in the following order: eating, sleeping, eliminating, dressing, and washing.

EATING

By two years of age a child should be able to feed himself—although with occasional spillings—if provided with proper utensils. These should include a small fork and spoon, with straight handles, a cup or a glass from which to drink, and a small plate. The child should be seated comfortably at a low table with a chair which permits his feet to touch the floor, or else in a chair with a footrest which is comfortable, at the adult table. The two-year-old should be eating three meals a day, with his heavy meal preferably at noon. Between meals he may be given fruit or milk, and perhaps plain wafers. His diet, with the exception of rich desserts and such meats as pork, will be similar to that of the adult, so that the feeding of a two-year-old should not be difficult to work into the family schedule and dietary. The child at this age will need to have his food cut up for him, but he should be given solid foods, and a variety of them. The progress made from two to five years is chiefly in skill in handling eating utensils and increased ability to chew, which reduces the length of time necessary for eating.

Some of the most frequently encountered problems are refusal to drink milk; dislike of foods, often vegetables; begging for everything which the adult eats; and, with the two-year-old, difficulty in chewing and swallowing.

SLEEP HABITS

In surveying sleep habits, the first information needed is the amount of sleep prescribed for different ages. According to H. C. Stuart in his book, *Healthy Childhood*, the average preschool child's sleep requirements are as follows:[1]

Age	*Hours*	*Minutes*
2 years to 3 years	12	42
3 years to 4 years	12	7
4 years to 5 years	11	43
5 years to 6 years	11	19

Again, it is necessary to realize that individuals may vary from the norm by needing more or less sleep. These figures are merely to be used as a helpful guide. Most authorities agree that it is better, during the early years, to break the day's activities by having part of the sleep quota in the form of an afternoon nap. However, by four and five years of age, naps tend to diminish and gradually drop out. How much this is influenced by the child's attitude toward sleep may justifiably be questioned. In order to establish good sleep habits there should be regularity of bed hour, preceded by quiet play, and preferably some consistency in preparation for bed. The bed should be sufficiently large, with a fairly hard mattress. From two to three years of age the child is approaching the time when he may be graduated from a baby bed to one without sides, which will enable him to be more independent.

His sleeping garments should fit loosely, but well. A preschool child still needs some supervision when preparing for bed, and someone to tuck him in at night.

Among the more prevalent sleep problems are those of asking to carry playthings to bed; asking for something after having been put to bed; waking up early and disturbing the household; difficulty in relaxing and falling asleep; and, with four- and five-year-olds, refusal to nap.

ELIMINATION

For habits of elimination, authorities differ markedly regarding the age when habit training should begin. There is more agreement, however, with reference to the time when a child should be expected to have controls established. In J. E. Anderson's book, *Happy Childhood*, this chart is given:[2]

	1 year	2 years	3 years	
Bowel	67%	90%	99%	Girls
control	60%	89%	98%	Boys
Bladder	49%	81%	95%	Girls
control	38%	79%	95%	Boys

It should be remembered that boys are somewhat slower than girls in establishing habits of elimination. No doubt the difference between bladder size for the sexes has a direct bearing on the problem, since preschool boys have smaller bladders than girls. In general, daytime urination should be established by two years of age and night time by three, whereas bowel control should be established somewhat earlier, between the first and second years. To help a child, he should be given correct terminology; he should have garments which are easily managed; and the facilities in the bathroom should be conducive to self-help, such as a box on which to stand. Two-piece underwear is the best to use during the early training period when accidents occasionally occur. Until a child has learned to button and unbutton underwear, complete responsibility cannot be fully established. By four years of age this should be achieved, however.

Courtesy Talon, Inc.
"A little bit independent"

Problems are more frequent for urination than for bowel control. Bed-wetting is usually caused by such sound slumber that the child does not waken voluntarily. Again, he may be taking too much liquid shortly before retiring. During the day, there are often interferences and activities which delay a child so that he fails to reach the toilet in time. In some cases, children do not willingly assume responsibility, and even though they are not busily occupied, daytime accidents occur. Sometimes clothing is so difficult to manage that unless an adult assists, accidents

occur, even though the child has gone to the bathroom. Whenever the problem of enuresis occurs, a good procedure is to first check any possible physical causes, then psychological causes; and when these are discovered, concentrate primarily on eradicating them.

DRESSING

By the age of two most children are showing an initial interest in the dressing process. At this time a child will help by holding out his arms and by handing garments to the one who is dressing him. Since it is easier to undress than to dress, the child at this age can pull off his stockings and shoes, and will try to put them on. By three he can undress, if helped with buttons, and by four he should be relatively independent both for dressing and undressing. By five years of age outer garments, such as wraps, should be included among the things a child can manage for himself. How much he learns to do during these years is directly related to the type of clothing worn as well as the opportunities allowed for experimentation by the child.

WASHING

The washing process is one which two-year-olds are showing an interest in also. At this age the child should be able to squeeze the washcloth and wash his face as well as his hands. There will be some difficulty in using the towel for drying. By three, a child is more skilled and accurate in his movements, which results in less dripping of water as he washes. By five, with the exception of such areas as ears and neck, a child can give himself quite a satisfactory bath.

Dressing and washing, interestingly enough, usually present at first the problem of the beginner who wants to do everything for himself, even though he is still incapable. Then by five years of age there comes the dawdling stage, when the processes no longer contain the original element of interest and fascination; and although the child should be comparatively independent, he has difficulty in performing a task with dispatch.

One of the advantages of a nursery school in the habit training of children is the fact that primary consideration is for the child. Consequently, in planning and executing the day's schedule it is easier to do so without irregularities and interruptions than it is in the home. Since the home is shared by all of the family members, it is not always possible to give the concentrated attention and help which might be desirable at the time. However, a nursery school cannot supplant the home; it can only serve as a supplement. How satisfactorily the child is helped in the nursery school depends upon the cooperation which exists between the school and the home, since the child's upbringing rests chiefly within the home. Consequently, one of the most important approaches to satisfactory child guidance is through the avenue of parental education.

PARENTAL EDUCATION

To help parents more adequately fulfill their rôles in the training of children it is necessary to build in them a feeling of confidence in their own ability to succeed. This is the first and most essential step. If in addition, parents can be helped to understand something of growth and development and how it takes place, they are equipped to use their self-assurance and confidence in wise and intelligent guidance. They must be made to realize that children learn by doing, and even though it may require patience and fortitude, skills develop only through the chance to practice. They should also realize the need, at times, for manipulating a situation in order to make the results either satisfactory or unsatisfactory. The parent who understands how to use punishment knows that it should relate directly to the act, and that it is justified only if

the child learns better how to act in a similar situation later.

If those people who function in an advisory capacity to parents appreciate the rôle of habit formation and understand the guidance of children in learning, they in turn can make an invaluable contribution to the lives of growing girls and boys through helping parents to a better insight and understanding.

REFERENCES

[1]Stuart, Harold C. Healthy Childhood. D. Appleton-Century Company, New York, 1933.

[2]Anderson, John E. Happy Childhood. D. Appleton-Century Company, New York, 1933.

Blatz, William E., and Bott, Helen. Parents and the Preschool Child. William Morrow & Company, New York, 1929.

Faegre, Marion L., and Anderson, John E. Child Care and Training, University of Minnesota Press, Minneapolis, fourth edition, 1937.

Langdon, Grace. Home Guidance for Young Children. John Day Company, New York, 1931.

Rand, Winifred, Sweeney, Mary E., and Vincent, E. Lee. Growth and Development of the Young Child. W. B. Saunders Company, Philadelphia, second edition, 1934.

Sherbon, Florence B. The Child. McGraw-Hill Book Company, New York, 1934.

Thom, Douglas A. Everyday Problems of the Everyday Child. D. Appleton-Century Company, New York, 1927.

NURSES IN THE MAKING

The place of public health nursing in the education of student nurses today is interestingly presented in a motion picture on nursing education just released by the Harmon Foundation. The film is called *Nurses in the Making* and was produced by the Division of Visual Experiment of the Harmon Foundation, in coöperation with The New York Hospital School of Nursing, the Henry Street Visiting Nurse Service, and others.

The picture opens with scenes from various fields of nursing service. Nurses are shown at work in hospital, home, school, industrial plant, and with the American Red Cross and the Frontier Nursing Service. The main body of the film presents the highlights of a modern nursing curriculum, after indicating the type of young woman who should enter nursing and the requirements for admission to a good school. The attention given to the student's health and her opportunities for recreation are included, as well as the classroom and laboratory study which accompany her nursing practice. The carefully supervised practice in the various services is shown, with emphasis on the way the student learns not only to do but to teach. The accompanying illustration of a student nurse in a patient's home is taken from the section of the film which depicts the affiliation with a visiting nurse association.

Nurses in the Making is a two-reel, 16-millimeter silent film, which takes about a half-hour to show. It may be rented from the Harmon Foundation, 140 Nassau Street, New York, N. Y., for three dollars a showing plus transportation costs. Prints of the film may also be leased for the lifetime of the print. Public health nursing organizations can make effective use of such a picture to show the public the scope and thoroughness of the education which prepares the modern nurse for her important place in the community.

The Modern Board Member

By ARTHUR DUNHAM
Professor of Community Organization, Institute of Public and Social Administration, University of Michigan, Ann Arbor, Michigan

This characterization of the modern board member is equally as applicable to public health as to the social work field

BOOKER T. WASHINGTON once defined a board. A board, said he, is something that is long and hard and narrow. Frederic Almy had a somewhat similar idea when he wrote:

> Boards are not made of living wood;
> No young sprigs on a board are fitting.
> Sap makes things grow, you know, and could
> Disturb a Board's perpetual sitting . . . . . .
>
> Creative youth makes change and motion
> And many a Board prefers to sit.
> It sits on youth, without a notion
> That youth instead should sit on it.[1]

One of the earliest published discussions of the place of the board member in modern social work was Ada E. Sheffield's pamphlet, *The Charity Director,* written from that home of capable and understanding board members, Massachusetts, and published by the Russell Sage Foundation in 1913.

CHANGES IN TWENTY-FIVE YEARS

The board member of today who casts a glance back over the 25 years that have elapsed since Mrs. Sheffield wrote her pamphlet sees that vast changes have taken place in this field of human activity. Social work has become more highly organized and more highly specialized. It has less of the crusade and more of the closely knit, day-by-day working organization about it today. Moreover, social work is in process of becoming a profession. We have begun to recognize that there is a need for skill and training on the part of the person who is to be entrusted with the delicate responsibilities of dealing with human beings in trouble, of leading groups of young people or older people, and of developing broad community programs of social work.

In this one short period of time, social work has passed through two of the greatest cataclysms that have ever rocked our country: the war and the depression. The war, as one of its minor effects, brought about an immense development of organization within the welfare field, and part of the heritage of this period of organization has been the rise of the community chests. For those who have always known the community fund as a part of our social equipment, it may be difficult to imagine social work without it. And yet, up to the days following the war, community funds were practically unknown. Each agency had to make its own way financially, and the board member's life sometimes seemed a pilgrim's progress over a road strewn with deficits. How different is the situation today, when the voluntary welfare agencies of the community pool their forces and present a single civic appeal to the citizens of the community! The board member of today and the agency of today are much less alone than they were twenty-five years ago.

Out of all of the bitter experiences and struggles of the depression has come a clear realization that from the quantitative point of view, public wel-

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Based on an address at the annual meeting of the Community Fund, Ann Arbor, Michigan, April 27, 1937.

fare work is the basic pattern in the field of social service. Indeed, we have passed through a period of questioning as to whether there was still a place in the picture for private social work. We are not asking that question today. We know the answer. There is a continuing place for voluntary social work. It is not a luxury but a necessity. We require private social work as well as public, to meet our community needs. Porter R. Lee has pointed out "the inevitable lag between any kind of statutory provision for meeting human need and the scope and character of such need in the community."[2] We need the private agencies, also, as pioneers and trail blazers. Moreover, we must have the leadership of the private agencies in building and maintaining a sound public welfare program. This last function is of particular importance in this present period of welfare development which is characterized in so many states by the sweeping reconstruction of traditional programs of public welfare.

PLACE OF THE BOARD MEMBER

The board member who has thus looked back over the recent history of social work will turn with a new interest and appreciation to the examination of his task as a board member of today. He may find himself asking some of these questions: What is my job as a board member? Where do I fit in? What part do I have to play in carrying on these social welfare undertakings in my own community?

Obviously, the board member has certain *official* relations. He is a representative of the members of and contributors to the agency, and in a larger sense a representative of the whole community in the management of the agency. He is a trustee charged with the stewardship of the agency's funds and with the proper direction of the enterprise. He is a legislator with responsibility for determining the broad outlines of the agency's program and the policies which will serve as guiding principles in the carrying on of the agency's service. Also, of course, the board member is a director, a member of a board charged with the appointment and supervision of the executive of the agency and through him of the staff of paid workers.

Let us turn, however, from these official relationships to the more searching question of the individual contributions of the board member. In modern personnel practice when one wishes to secure an employee for a particular job, the first step is to prepare a job analysis for that job. What is it that this employee is going to do? What kind of a person do you want to do this kind of a job? It may be of value to attempt a somewhat similar process with the job of being a board member. What are the things that we expect a board member to do in social work today? What kinds of services will he contribute? I should like to suggest briefly six things which it seems to me should characterize the board member of today. I am speaking particularly of board members of private agencies, but most of these points apply to members of public welfare boards as well.

In the first place, a board member is *a member of a constituency*. We may think of a series of concentric circles such as the widening ripples which are seen when a stone is thrown into a pool of quiet water. In the innermost and smallest of these circles are found the professional social workers who are giving full time and (we hope) trained and qualified service to their jobs. The next circle represents the board members and volunteers. Next to the professional social workers, the board members and volunteers are closest to the work of the social agency, know more about it, and give the most time to it. Beyond the board member group is a wider and vaguer circle of contributors to social

work, and beyond the contributor group the circle fades out into the general public.

In this picture, we can not over emphasize the importance of this inner group, of board members. They are the nucleus of a citizen constituency for social work; they represent the community in reference to voluntary social work.

We have about 128,000,000 people in the United States. There is not the slightest chance that in this generation (or perhaps in any other generation within the next century or two) we can educate all or even most of these people as to what modern social work is all about. Fortunately, we do not need to do this. We can concentrate primarily upon the key people—the leaders of groups and molders of public opinion. In a substantial degree, the board members are or should be these persons. To a greater degree than we have ever recognized, the future of both public and private social work is bound up with the development of an intelligent, alert, understanding, *thinking* constituency—a group who have some first-hand touch with social work and its problems and who can speak disinterestedly but with conviction and authority to their fellow citizens. To this constituency, then, the board member belongs.

In the second place, if the board member is to belong to this constituency, *he must know something about social work as a whole, and a great deal more about his own agency.* Dr. Michael Davis has said that part of a board member's job is "to know why the organization exists, and annually to review why it should." The board member must have an inside knowledge of the program of his agency. What is it trying to do in the community? How well is it equipped to do the job—in terms both of staff and of material equipment? Does the agency use modern and effective methods of work? Does it measure up to the best standards of accomplishment in its field of social service? What are its relationships to national or state organizations in its field? Is it business-like and efficient in its administration? Has it a well thought-out program for interpreting its work to the community? In short, how good a job is it doing? What are its relationships with other welfare agencies in the community? And what are its needs and problems? The agency that is conscious of no major problems has cause for real alarm. The problems are there—it is the agency that has not the ability to recognize them as problems.

THE BOARD MEMBER IN THE GROUP

The board member should also *play a part in the board as a collective group.* Board meetings are important. The board meeting is the only time, generally speaking, when the board functions as a group. There the basic decisions regarding the agency and its program are made.

The board meeting should be an expression of group thinking. Mary P. Follett in *The New State* has pointed to group thinking as the basic process of democracy. "I do not go to a committee meeting," says Miss Follett, "merely to give my own ideas. If that were all, I might write my fellow members a letter. But neither do I go to learn other people's ideas. If that were all, I might ask each to write me a letter. I go to a committee meeting in order that all together, we may create a group idea, an idea which will be better than any one of our ideas alone, moreover which will be better than all of our ideas added together." The group idea is far different from the majority idea. "To a genuine group idea every man must contribute what is in him to contribute . . . No member of a group which is to create can be passive. All must be active and constructively active."[3] The es-

sence of a board meeting, then, is not "approving the minutes as read," making motions that reports be accepted "and filed," or passing complimentary resolutions to be "spread upon" the minutes. The board meeting should be a creative, adventurous undertaking on the part of a group of persons who know much about their subject, who are alert to the problems to be solved, and who are accustomed to taking counsel together and to evolving out of their very differences a dynamic integration of thought and unity of action.

It seems not unreasonable to think that the board member, in addition to his services as a member of the group, *should have some individual contribution to make to the agency*. I am not talking now about contributing money. We may surely assume that this will come in proportion to the board member's means, as a natural expression of his interest in the agency and in the broader community enterprise of the community fund, of which the agency may be a part. But quite aside from any financial contribution, there are many ways in which the members of a board may make invaluable contributions of services to the agency. The board member may make himself available, on request, for individual consultations with the executive or members of the staff. He may be able to contribute technical advice and help from the standpoint of his own vocation as a lawyer, a doctor, a banker, an accountant, a research specialist, an editor, or a realtor. He may take the chairmanship or give active service on one of the committees of the agency, the community fund, or the council of social agencies. It is true, as a weary cleric once observed, that it is not altogether certain that the Kingdom of God will be brought to pass by means of committees. But it does seem reasonably certain that a large proportion of the activities of our modern community life will have to be carried out with the aid of the committee process. A board member also may be an adviser and counselor and in a sense a representative regarding some special group in the community with which he is connected. The board member may serve as a liaison officer between a social agency and a religious denomination, a women's organization, a men's service club, a racial group, organized labor, and a variety of other groups in the community.

One of the most important functions of the board member is *to help interpret the agency to the community*—its program, its needs, its methods of work. The private social agencies of any community depend for continued life upon voluntary contributions from the public. Those contributions depend upon the public's understanding of the agency, the public's belief in the need for the agency's work. There is no more vital area than public relations in the field of modern social work, and beyond all formal publicity methods are the immense possibilities of informal, individual day-by-day interpretation by the board member to those with whom he comes in contact. It is this sort of interpretation that plays so large a part in the building up of acceptance and community goodwill.

Finally, the board member *should have a part in the community welfare program*. He will normally wish and expect to play some part in the annual community fund campaign. As a group, the board members will form an important nucleus of the campaign organization, for who are better equipped to "sell" the work and services of the agencies than those who actually direct their programs? Not every board member is fitted to make a good campaign solicitor. But a large proportion of the board member group ought to be active in the campaign in one way or another, whether through soliciting, serving under the speakers' bureau in reaching all

kinds of groups, giving special committee services, or performing some of the modest but necessary clerical or administrative functions incidental to the carrying through of an effective campaign.

However, we shall miss the real meaning of the community fund campaign, if we think of it merely in terms of a joint money-raising effort. It is this, of course, but it is infinitely more. It is a civic venture in which we stand together in presenting to our community its obligations and its opportunity to make life more worth living for men and women and boys and girls, our neighbors and fellow citizens, who are part of the present and the future of the community in which we live. Social work is not a narrowly limited interest or activity—it deals with fundamental matters of human relations and of community life. In the community fund and council of social agencies we have two organizations which are concerned with the welfare of the community as a whole. In the activities of these two communitywide agencies, in the rallying of civic statesmanship for which they stand, there is a climax to the service of the board member. Here is the opportunity for the fullest expression of all that the board member has to give to social work. Here will be used to the full his status as a member of the constituency; his knowledge of social work as a whole and of his own agency; his understanding of the group process, and his willingness to make his own individual contribution; his service as an interpreter, and his participation in a great community venture.

And the objective, the ultimate goal of this venture? It has been phrased in these words which may serve as an expression both of the social worker's and the board member's ideal of social work: "Our common objective is nothing less than a society so ordered that every human being within its circle shall have the largest possible opportunity, the greatest possible incentive, to realize his full potential self, and so make his own full unique contribution to the well-being of the whole."[4]

REFERENCES

[1]Almy, Frederic. "On the Use of Boards." *Survey*, December 1, 1923. Page 265.

[2]Lee, Porter R. "Social Workers: Pioneers Again." *Survey*, September 1933. Pages 307-312.

[3]Follett, Mary P. The New State. Longmans, Green, New York, 1918. Pages 24, 28.

[4]Pray, Kenneth L. M. Presidential address, Pennsylvania Conference on Social Welfare, Wilkes Barre, Pennsylvania, 1924. Sixteenth Annual Meeting, Proceedings. Page 4.

GUIDE POST FOR BOARD MEMBERS

The significance and purpose of the revised *Board Members' Manual*, prepared by the National Organization for Public Health Nursing, are discussed in an editorial on page 615.

The responsibilities and qualifications of a board member are analyzed on page 629.

The importance of pneumonia as a public health nursing problem is shown on page 653.

Can the care and education of the crippled child be effectively coördinated? Wisconsin's dual program for the crippled child is described on page 642.

The number of public health nurses in the United States today is compared with the number in 1931. Page 648.

The Surgeon General of the U. S. Public Health Service shows the vital place of nursing in the modern public health program, in his address at the N.O.P.H.N. Silver Jubilee dinner at the A.P.H.A. - N.O.P.H.N. joint meeting. Page 617.

Some important aims of child training in regard to habit formation are discussed on page 623.

The Medical Unit Reports to Management

By FLORA K. ARNOLD, R.N.
Industrial Nurse, Medical Unit, Chemical Bank & Trust Company, New York, N. Y.

A nurse in a large financial institution makes a report to management on the services of the medical unit

MUCH has been written about the growing interest of business executives in medical units and in the contribution of industrial health service to low-cost production, through improved health conditions. This is and will continue to be looked upon as so much propaganda by many industrialists. One writer expresses this succinctly, "If it is not necessary to output, put it out," which is followed by his statement that a medical unit functioning adequately and performing great service was eliminated by an efficiency expert installed by a financial institution to assume the task of reorganization.

Professional people sometimes do not realize that business must obtain a return on its investment, whether it be an investment in manpower, machinery, or a medical unit. In modern industrial organization, the importance of return on an investment is considered paramount. At the same time there is no subject about which so little has been written in connection with medical units. Business will be wholeheartedly behind medical units in industry only when management is given a practical analysis of activities and results obtained by the medical unit, together with recommendations for a program to bring about improved health and lower absence rates in order to cut costs. The presentation of such a report should be clear, concise, non-technical, and understandable to a non-medical reader.

We have attempted to face these facts in our reports to management and we consider them of vital importance in interpreting the value of service. After a brief description of our health service, part of our annual report will be described and reproduced.

The medical unit of the Chemical Bank & Trust Company was organized in 1934. The bank—which covers Manhattan and Brooklyn, New York—is composed of 12 branches beside the main office, and employs about 1500 people. The unit is composed of a non-resident consulting physician and a full-time nurse. Typing service is furnished from the secretarial department.

The physician makes preëmployment examinations, and subsequent examinations in special cases when requested to do so. Employees who have no family physician and who wish to go to the consulting physician for further consultation are given special financial consideration. He is called for emergencies requiring the immediate service of a physician.

The nurse has the responsibility for day-by-day health supervision of employees. She receives a report of the preëmployment medical examinations from the physician—who makes the examinations in his office—and does the follow-up to secure correction of defects and handicaps. She gives first aid in injuries when needed, though emergencies are a very minor part of the work in a business of this type. She checks up on all absences due to illness after the employee returns to work and ascertains the cause.

The health service is centralized and the employees come to the main office

to see the nurse. After absence due to illness, all main office employees report to the nurse before returning to work. Branch office employees are not requested to report to the nurse for an absence of less than two days. This routine is frequently waived depending upon the type of case and previous health record of the employee. The nurse sends a form report to the department head or branch manager after the employee returns to work. In certain cases a certificate from the family physician is required for an employee who has been absent over four days. Employees also report to the nurse, on the advice or permission of the department heads or branch managers, for special reasons. These visits to the health office are made on bank time. The nurse visits the branches periodically or on call, for consultation on health problems or environmental conditions that cannot be handled in the main office.

Since the nurse is the full-time member of the medical unit, it is her responsibility to make the reports of the service. Monthly and annual reports are made to the personnel director, who is a member of the management committee. The report is read by the various members of the committee, all of whom are officers of the bank. The first monthly reports which were made after the unit was started in 1934 contained a careful causal analysis of absences as compared with the previous month and the same month of the previous year; a list of the factors that might be entering into an increase or decrease in absences; a notation on the responses of employees to the new regulations of the management in regard to reporting after illness and the effect of this measure in preventing loss of time from relapses; an analysis of potential absentees, with medical recommendations regarding corrections of defects; a causal analysis of absences with number of days lost classified by departments; and an analysis of cases handled according to disposition of the cases (see page 637).

Now that three years have passed, it is no longer necessary to present quite such detailed monthly analyses. Significant facts are reported each month; and unusual occurrences—such as an unusual amount of absence from epidemics of colds—are studied, especially in comparison with absences in other similar business organizations, and are reported to management. A very detailed annual report is still made, and portions of the 1936-37 report are reproduced here with the permission of the management in the hope that they may add to the material on this subject and be of interest to other industrial nurses.

ANNUAL REPORT—1936-1937

FOREWORD

In this, the third annual report of the medical unit, we have attempted to make comparisons which will be of assistance in formulating the program to be followed by the unit during the coming year, so that everything possible may be done to reduce, by prevention, the most frequent and costly ailments. During the three years the unit has been in existence it has been proven that many ailments can be prevented and more serious cases alleviated if they are detected in their early stages. The prevention of disease is now recognized universally as being far more important and less costly than treatment and cure.

Considerable research work has been done by us, in the bank and through outside companies. The consensus is that the desired results for better health and for a decrease in rate of illness among employees cannot be accomplished with halfway measures. Our program now lacks an annual physical examination. This is accepted as the most valuable means of discovering incipient conditions for which corrective measures can be instituted early, before irreparable damage has been done.

Although it is realized that it is in no

sense the aim of management to maintain a health service as a major objective, the health service in industry has reached its present important position through the gradual and increasing recognition and appreciation of its potential contribution to the original objective—production at low cost.

INCREASED USE OF FACILITIES

The percentage of employees using the facilities increased from 60 percent in 1934 to 95 percent this year, indicating that employees have recognized and are taking advantage of the benefits to be derived from the unit.

COMMENTS ON ABSENCES AND CAUSES

*Absences**	Days
Total absences	.....
Increase of absences over 1936	.....
Total sick leaves (enforced and by permission)	.....
Increase of sick leaves over 1936	.....

Sick leaves include surgical operations to correct conditions which will tend to decrease recurring absence in this group.

Despite the epidemic of grippe and influenza during the past winter, our absence did not increase proportionately with the increase in number of people employed. Saturday and Monday absences due to illness frequently showed an increase over the balance of the week. Certain departments [enumerated in report] had higher absence rates—both number of absences and number of days absent—than other departments. The type of work and working conditions may have influenced these higher rates.

Causes

If we are to accomplish our aim of improved physical condition of our employees with the resultant reduction in absence, we must systematically attack the causes of the most frequent and longest illnesses. An analysis of absences in relation to causes shows that:

Of the total ***number of days*** of absence, respiratory ailments, major operations, circulatory and genito-urinary ailments caused 70.3 percent.

Of the total ***number of absences,*** respiratory, digestive, and one-day ailments (branches unchecked) represented 77.5 percent.

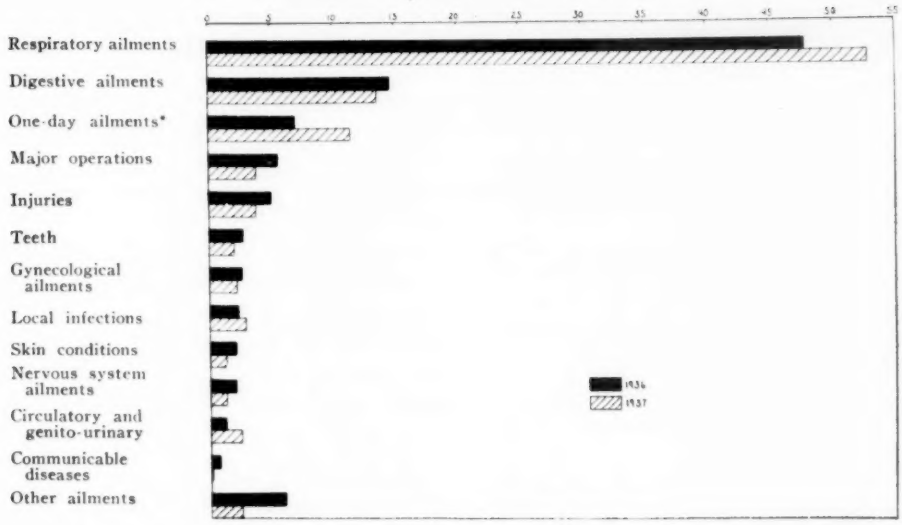
"Respiratory ailments" heads both lists and represents a real problem. The medical director of a large business states they have been using oral vaccine for the past two years for "cold susceptible" employees. They have been very much encouraged with the results obtained, and plan to repeat the use of it this year. The simplicity of the vaccine's administration and the fact that their medical unit has not been informed of any unfavorable reaction to its use are greatly in its favor.

The fluoroscopic examination (with x-ray study when necessary), included as of April 15, 1937 as a routine part of the preëmployment physical examination, is a step universally recognized as a most reliable means of detecting minimal tuberculous lesions. Our experience has been too short to make any comments other than that we have not employed anyone with recognized tuberculosis. Our medical consultant will submit his report at the end of six months. It may be said, however, that unless we follow this with a routine examination of old employees not fluoroscoped or x-rayed, we shall miss certain existing cases of tuberculosis, which experience has shown often exist among old employees. Sooner or later these old cases may be infecting the new employees.

Circulatory and genito-urinary ailments, diseases of the nervous system, general run-down conditions, and diabetes have been the cause of practically all very long absence among employees over forty years of age during the past

*The actual figures have been omitted, for the most part, from this reproduction of the report.

PERCENTAGES OF ABSENCES BY CAUSE, 1936 AND 1937



three years. These conditions could be alleviated to a great extent if they were detected *before* reaching such an advanced state. This can be done only on the basis of physical examinations.

Cost of absence

Days of absence .....
Average wage per day (arbitrary) .....
Estimated cost of absence to the bank, 1936 .....

Using the Federal Government statistics, that the cost is one and one-half day's salary for each day lost, the cost would be .....

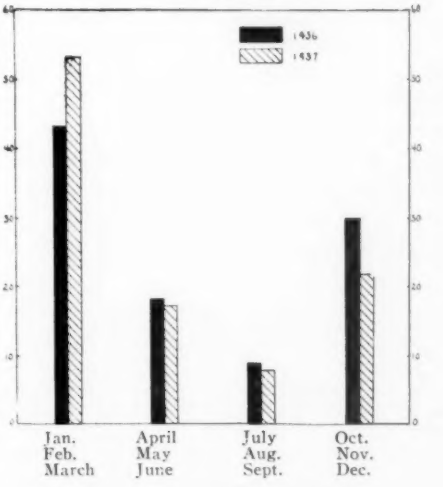
The adoption of a program of cold prevention, and control of tuberculosis and of diseases prevalent among those over forty years of age should substantially decrease our absence. The ultimate saving should more than offset the expenditure, by improved efficiency accompanying good health. Our amount of absence did not increase proportionately with the increase in number employed, which we believe is due to the precautionary measures heretofore instituted.

Compensation cases

Number of compensation cases treated .....

*Bank branches unchecked.

PERCENTAGES OF ABSENCES CAUSED BY RESPIRATORY AILMENTS, BY SEASON, 1936 AND 1937



Number of employees losing time .....
The longest absence, due to bursitis of the knee was ..... days.

*Associated Hospital Service of New York**

Number of employees benefited .....
Total days of hospitalization .....
Average number of days per person hospitalized .....

*A coöperative hospital plan in New York City.

Control of syphilis in industry

There has been a great deal of study and publicity recently on the subject of syphilis, a cause of many degenerative diseases. It is felt that we, too, should participate in the distribution of educational material. We have reviewed many articles on the subject and have briefed them for perusal by management.* A brochure on the subject published by the Bureau of Social Hygiene, New York City Department of Health, has been distributed to employees.**

General

Real progress has been made in having correctable defects in our employees corrected, such as removal of diseased tonsils, appendectomies, corrections in vision, and dental care. While this has caused some increased absence it will prevent recurring absence in the future.

Many employees sought advice in connection with personal difficulties relating to family illness which have caused them a great deal of mental worry and financial concern. We have been successful in many instances in relieving such anxiety, through cooperation with the proper agencies.

Policies established—1936-1937

1. Fluoroscopic examination (including x-ray study when indicated) as a routine part of preëmployment examinations.

2. Definite policies with regard to sick leaves.

3. Definite policies with regard to applicants' preëmployment physical examinations.

(These policies, established this year, are based on a study made over a period of three years.)

Recommendations

1. That we establish annual physical examinations for all employees, to include as a routine the fluoroscopic examination of chest, and an electrocardiogram study on all employees over forty years of age.

2. That we plan to make further studies on cold prevention.

3. That we more frequently use the insurance company nursing service. This is a free service under our group policy and we feel that in many cases the length of absence can be reduced by earlier and more efficient care.

4. That branch employees having more than three one-day absences per year have a check-up to see if any chronic condition or correctable defect exists.

COMPARISON OF STATISTICS FOR EACH OF 3 YEARS: 1935, 1936, 1937

	1935	1936	1937
Number of employees			
Male			
Female			
Total employees			
Employees using facilities (including officers)			
Number			
Percent of total employed			
Outside people given emergency treatment			
Cases handled			
Total			
Peak month			
Number of cases			
Month			
Days of absence due to illness (excluding officers)			
Long term (7 days and over)			
Male			
Female			
Total			
Short term (under 7 days)			
Male			
Female			
Total			
Total			
Male			
Female			
TOTAL DAYS ABSENCE			

*See Research Findings, page 639, for a further discussion of these data.

**Bureau of Social Hygiene, Department of Health of the City of New York. Facts About Syphilis. 1936. Copies of the digests of articles and of the pamphlet were attached to the report as submitted to the personnel director.

DISPOSITION OF CASES HANDLED

	1935	1936	1937
Surgical aid			
Medical aid and advice			
Follow-up of cases, including check on medical cards			
Referred to doctor			
Employee's expense			
Bank's expense			
Compensation cases			
Referred to clinic			
Referred to home			
Rest periods in medical unit rest room			
Cases hospitalized			
Cases given home and hospital visits by nurse			

Tables were also included to give the following information:

1. A comparison of the service with that of six other companies, in regard to total number of employees, number of cases handled, number of days of absence, number of employees absent, average days of absence per person, and number of resident medical staff.

2. An analysis of absences according to causes.

3. An analysis of absences and days of absence for the year according to departments in which they occurred.

4. A list of the employees absent more than seven days or having more than three absences during the year, with the department, absence frequency, number of days of absence, and cause of absence.

5. A list of employees absent for an extended period of sick leave during the year, with the department, number of days absence, and cause of absence.

6. A list of employees given sick leave for surgical operations to improve their general health, on the advice of the consulting physician or the patient's own physician, with the department, number of days of absence, and operation performed.

7. A list of employees showing marked deviation from average weight and in need of special attention because of glandular or other organic disturbance, with the department, and figures showing gain or loss in weight.

8. A list of compensation cases, showing the disability and number of days lost in each case; an analysis of the total number of compensation cases according to total days lost, and number of compensation cases having absences.

9. A list of the employees hospitalized under the Associated Hospital Service of New York, classified according to the name of hospital, the number of hospital days, and the diagnosis.

Items 2-7 are used as a basis for future follow-up by the nurse.

*This may be either the company nurse, the visiting nurse, or an insurance nurse.

RESEARCH FINDINGS

During the year a careful investigation and study have been made of the industrial relations policies followed in the United States in industrial, manufacturing, and financial institutions, and a treatise on the subject has been prepared from data obtained from state and national health agencies, insurance companies, and medical units of other industries. Information on the following subjects is included in this treatise so that inferences may be drawn which will be of value in the consideration of future policies:*

Medical service in industry
Diseases related to industry
Cancer
Degenerative diseases
Syphilis in industry; syphilis control program
Diabetes and tuberculosis—a change in the mortality picture
Meeting the tuberculosis situation
The cost of tuberculosis to industry, to the individual, and to the community
Most frequent causative factors of heart disease
The work environment and fatigue
The physical examination
  Preëmployment examination
  Reëxamination
Objectives of industrial health nursing service.

EDUCATIONAL LITERATURE

Educational literature has been given to employees on various subjects related to their health needs and problems—such as colds, influenza, pneumonia, first aid, and keeping fit through exercise.

*Treatise omitted here.

I Christen Thee . . .

HOW DID the N.O.P.H.N. get its name? This question is often asked by the younger nurses who did not have the privilege of participating in the eventful days of our founding. We are quoting here from the Report of the Proceedings of the Section on Visiting Nursing of the 15th National Convention of the American Nurses' Association, held in Chicago, Illinois, June 5-7, 1912. This report is reproduced from *The Visiting Nurse Quarterly* for July 1912. Miss Edna L. Foley, Superintendent of the Chicago Visiting Nurse Association, presided. In order to understand the discussion it should be remembered that the participants are speaking as members of a section of the American Nurses' Association—a section whose members were considering the formation of a new organization.

CHAIRMAN: Edna L. Foley*

Motion has been made and seconded that we organize as the "National Association of Public Health Nurses." . . . "The National Association of Visiting Nurses," "Public Health Nurses," and the "National League of Public Health Nurses," have all been suggested. . . . .

MISS CRANDALL: At the meeting of the Superintendents' Society** the other day the question was raised as to whether one association could be a member of another association; and may I ask Miss Delano if that term was used because they chose it? I am not clear about this.

MISS DELANO: I heard no objection to the use of the term "association" in the meeting of the Society. I did hear objection to the use of the term "league"; whether that would not be confusing with the Leagues of Superintendents and Nursing.**

CHAIRMAN: Are there any further discussions?

MISS CRANDALL: If there is any question about the word "nurse" or "nursing," I believe it would sound better to say "nursing."

CHAIRMAN: Thus reading: "National Association for Public Health Nursing"?

MISS HICKEY: Why not leave that to Miss Crandall as to which would be the better wording; I think we should have our association along lines affiliated with our great standard of Teachers' College.

MISS CRANDALL: I appreciate very much, ladies, Miss Hickey's referring the matter to the college; it does not seem to me so vitally important whether we say "National Association of Public Health Nurses" or "National Association for Public Health Nursing," but I do think "nursing" is a little stronger, as we are an association of nurses and their boards.

MISS DENNY: We have the "American Red Cross Association" and the "American Nurses' Association," and as these other associations are national, why could we not have the title: "American Public Health Association"? This is merely a suggestion.

MISS CRANDALL: If I may answer that: It was suggested and discussed by Miss Wald, who you know has membership in many national organizations, and the advantage of the use of the word "national" was that we would then conform to the political and other organizations of the country. As we have municipal, county, and national, so we hope to work down instead of up.

*For biographical data regarding some of the participants in this discussion, see Fox, Elizabeth G. "The Past Challenges the Future." PUBLIC HEALTH NURSING, May, 1937. Information about the other participants will be appreciated.

**The American Society of Superintendents of Training Schools for Nurses became the National League of Nursing Education in 1912.

and still we can corral our members for anything we want to do for registration or any other adaptive measures.

MISS DELANO: That would be a new term, different from our own—"National Organization for Public Health."

CHAIRMAN: We are not permitted to amend an amendment to an amendment because we cannot "patch a patch on a patch," but if those assembled would rather have "organization" I will amend the amendment and make it "National Organization for Public Health Nursing."

I think the word "for" means more than "of," because "for" would include all of our boards as well as ourselves, while "of" would be more or less personal. [Italics ours.]

MISS HICKEY: I make the motion that we organize here, and now, as the "National Organization for Public Health Nursing."

MISS COMBS: I second the motion.

CHAIRMAN: It has been moved by Miss Hickey and seconded by Miss Combs that we organize here and now as the "National Organization for Public Health Nursing."

MISS DAMER: What kind of a nurse is a "health nurse"? We are all "sick" nurses, are we not?

MISS JOHNSON: Does not the term "nurses" now mean that we are guardians of public health?

CHAIRMAN: It seems to me that this vote is such an extremely important one it should be taken by a rising vote. The motion that has been made and seconded is, that we organize here and now into the "National Organization for Public Health Nursing." All in favor of this motion, kindly rise.

CHAIRMAN: Thank you. It is a vote and as far as I can see, is unanimous. We therefore organize into the "National Organization for Public Health Nursing."

(A discussion of the proposed constitution, article by article, also election of officers and Board of Directors, here followed.)

How Would You Answer These?

This month's questions on maternity nursing are, we believe, especially provocative of critical thinking. They deal with fundamental questions affecting the quality of maternity nursing service. We hope they will intrigue your interest and stimulate your thinking. That is their purpose. We shall not know whether it is successful, however, unless you send in your answers. Won't you send them in, signed or unsigned, to the Maternity Center Association, 1 East 57 Street, New York, N. Y.

1. **How can we find out what the nurse who participates in home delivery services really needs to know over and above what the average nurse now knows?**
2. **What additional content beside that now given in our N.O.P.H.N. "Manual of Public Health Nursing" would you consider necessary to set standards for a home delivery service?**
3. **What items are now included in the public health nurse's "Labor Record"? Are these adequate? If not, what additional items would you suggest?**

What questions on maternity nursing would you like to have discussed through this column? Send in your questions to the same address.

The winner of the contest for an obstetric reference library will be announced in the December magazine.

Wisconsin's Dual Program for the Crippled Child

By FLORENCE L. PHENIX, R.N.
Assistant Director, Crippled Children Division, State Department of Public Instruction, Madison, Wisconsin

Believing that the care and education of crippled children cannot be divorced, Wisconsin places responsibility for both under one state administration

THE program for the care and education of crippled children in Wisconsin was established on the theory that physical restoration and academic education must proceed concurrently in order to obtain the most desirable results. The Crippled Children Division was established by law in 1927, as a part of the State Department of Public Instruction. This Division is responsible for the elementary and high-school education of crippled children under twenty-one years of age. The Division is also responsible for the program of physical restoration. This program includes the development of facilities for diagnosis, through orthopedic field clinics; for convalescent care as provided through the orthopedic schools; and for convalescent care and follow-up service as provided through the field staff of the Crippled Children Division. It is also the responsibility of the Division to assemble all records on individual crippled children in this state and to coördinate the efforts of the various agencies, organizations, and individuals working in behalf of these children.

Wisconsin is a state with a large rural population, nearly fifty percent of its residents living in strictly rural areas or in villages of less than 2500 population. There is, however, a good distribution of cities of 25,000 population or over, which are sufficiently large to maintain facilities for convalescent care.

The questions of housing and administration of convalescent facilities were decided upon the basis of prevalence and accessibility. In establishing convalescent care through the development of orthopedic schools, it was possible to utilize existing building accommodations and administrative organization in most instances.

EXISTING SCHOOLS USED

School buildings in most cities where the establishment of an orthopedic school was contemplated provided desirable quarters for the orthopedic school unit with a limited amount of building reconstruction. Ramps replaced stairways, and railings were installed at necessary points. Partitions in some instances were changed to produce a more desirable arrangement of space for the academic or the physical-therapy department of the unit.

While general policies regarding the administration of the orthopedic school program are determined through the office of the Crippled Children Division, local administrative responsibility is assumed by the superintendent of schools

of the city in which the orthopedic school is located. The academic program of the orthopedic school is the same as that of any other school in the city, and the orthopedic unit receives the assistance of special department supervisors employed by the board of education, as do other classes in the system. The children enrolled receive the same health supervision from the school nursing staff as is accorded the other children.

The faculty members of the orthopedic school are employed by the board of education of the city conducting the school. The teachers of academic subjects are usually chosen from among the group already employed in the system. The basis for selection is interest in this particular phase of special education and demonstrated ability in work with children. The physical-therapy technicians in the schools are employed by the board of education of the city conducting the orthopedic school, from candidates approved by the Crippled Children Division. Eligibility for employment in the physical-therapy department is determined upon the basis of membership in the American Physiotherapy Association, or eligibility for such membership; or upon membership in the senior classification of the American Registry of Physical Therapy Technicians, or eligibility for such membership.

Children are eligible for orthopedic school enrollment if they have a physician's prescription for physical therapy as given in the orthopedic school. The length of time a child remains in the orthopedic school is entirely dependent upon his physician's recommendations. At no time is the school considered a segregation unit, but is conducted entirely on the basis of providing convalescent care to children in a manner which will reduce to a minimum the length of time they must be removed from their own homes.

Orthopedic school facilities are available to children regardless of their place of residence. Those costs of conducting an orthopedic school which are in excess of the normal cost of education are paid through the funds granted the Crippled Children Division; while the city, village, or township of a child's residence pays the normal cost of education covered by tuition charges. The maintenance costs for non-resident children during the school week, when it is necessary for them to live away from home in order to receive orthopedic school care, are also paid through funds granted the Crippled Children Division. The parents or some individual or agency in a child's home community assumes the responsibility for the cost of maintenance for Saturday and Sunday if the child must remain in town, or for transportation between the child's home and the orthopedic school city when it is possible for him to return to his home for the week end.

Three orthopedic hospital schools are also maintained through funds granted this division. These schools are conducted on the basis of both classroom and bedside instruction. They are under the administrative direction of the superintendent of schools of the city in which the hospital is located.

The orthopedic field clinic program is conducted by the Crippled Children Division under the joint auspices of this division and the county medical society of the county in which the clinic is to be held. The local medical society issues the invitation to the orthopedists of their choice, selected from the list of orthopedic surgeons approved for clinic work by the State Medical Society. The children examined at the clinics are referred by their family physicians, or by welfare workers or community nurses. Following the clinic, reports regarding each child examined are sent the family physician and the community nurse, together with copies of any correspond-

ence relative to the care of the child.

Individual histories of every crippled child known to this division are kept in the office of the Crippled Children Division. There are at present active files on 8000 children under twenty-one years of age, having disabilities serious enough to constitute a vocational handicap. These case files contain medical, educational, and social information regarding the child. This information is made available to health and welfare workers who may be assisting the child. Hospital reports and reports of clinic examinations of children are automatically sent to all county and city public health nurses in the communities where the children live, as are also copies of any correspondence regarding these children. In turn, the community nurses supply the Division office with much valuable information regarding the various children and local needs.

The field workers employed through the Crippled Children Division are assigned to definite districts and are responsible for directing the activities in behalf of the children in their territory. The field staff are required to have the training of physical-therapy technicians —both prerequisite and professional training—as designated by the American Physio-therapy Association and the American Medical Association.

The crippled children program has been developed in Wisconsin in cooperation with already established services. All available facilities have been utilized and have been taken into consideration in the development of the program. The public health nursing program in Wisconsin is already firmly established. It is under the general direction of the Bureau of Public Health Nursing of the State Board of Health, and is the immediate responsibility of public health nurses employed in the capacity of county nurses, city nurses, or visiting nurses in the various communities. Because of the splendid nursing program already established through official channels, the Crippled Children Division has endeavored to establish facilities which would supplement nursing services already in existence and not duplicate efforts.

When the crippled-child program was initiated, the staff was very limited and it would have been impossible to develop a program of care and education for crippled children without utilizing every available service already established. Necessity was undoubtedly a contributing factor in determining this original trend, but experience in this state has demonstrated its value. The Crippled Children Division has established a specialized service to provide physical-therapy care to children when such care is prescribed by medical authority; to assist with the arrangements for hospitalization, artificial appliances, and educational opportunities; and to serve the local health and welfare workers in an advisory capacity regarding orthopedic cases.

THE AMERICAN JOURNAL OF NURSING FOR NOVEMBER

An English Nurse Describes the I.C.N.

By IRENE H. CHARLEY, S.R.N.*

Colorful and vividly told are these impressions of the International Congress of Nurses, by an English nurse

LONDON 1937 and America 1941! What kaleidoscopic memories and anticipations those magic words conjure up in the mind. The past! The future? But the purpose of this article is to tell something of the happenings during the International Congress of Nurses, which was held in July of this year in London.

"The meeting of the Congress will take place in the Central Hall, Westminster." So was announced this important nursing event in all the professional journals, and it was not long before London's friendly bus conductors and policemen were kept busy telling their many inquirers "to follow them ladies with the badges and you'll get there."

London's weather was on its very best behavior, just as though a special plea had been made for sunshine; and there was no lack of cheerfulness and color when the sun beamed amiably on the crowds of nurses hastening to their center of the world. No happier choice could have been made than the Central Hall, Westminster, which stands almost at the center of the city and is embraced by Westminster Abbey and the Mother of Parliaments through whose doors during recent months the pomp and pageantry of a British Coronation had passed.

There were 3362 registered members gathered in this spot, and flags of all nations welcomed the world's nurses to their great congress. The complete list of delegates is a trial to our geographical knowledge, but the privilege of discussing our common problems with colleagues from 43 countries was an inspiration so stimulating that the results can only be measured when once again we meet to weigh in the balance the work which has been accomplished in the interim.

The sessions were grouped under the following subjects:

1. Nursing education
2. The nursing profession, organization and administration
3. Public health
4. Some nursing problems, under which topics were discussed such as:
   The professional responsibility of the registered nurse as a citizen
   The need for compulsory state registration of nurses
   The minimum training needs to qualify for public health
   Work in countries where there is urgent need for more nurses
   The nursing of the chronic sick

To public health nurses a cursory glance at the attractive program might not indicate that their own subject was receiving much attention. Nothing was further from the truth. To the writer there were two important indices apparent during the proceedings. First was the fact that the public health group on the opening day so far overflowed the large hall which had been allotted them that an arrangement was made for the session to be moved to the Central Hall, where the ground floor was well filled. Such was the interest taken in the public health program!

Second, what can be more encourag-

*Miss Charley is Superintendent of the Central Bureau of Insurance Nursing, Nursing and Welfare Superintendent of the Mutual Property and General Insurance Company, and Honorable Secretary of the Public Health Section, College of Nursing, London, England.

ing to a public health nurse than to read that important sessions were given over to such questions as: "To what extent should the general nursing curriculum include theoretical and practical instruction in public health, psychiatry, maternity nursing, pediatrics, communicable disease nursing, and dietetics?" It does not seem long ago that as public health nurses we somewhat timidly dared to criticize our preparation and suggested that we would like to know just what public health meant, when we were still probationers.

PREPARATION FOR PUBLIC HEALTH

But in London in 1937, those responsible for our education more or less took it for granted that such subjects should form a basis of the general training. The following was the opinion of Canada: Nursing today is a community service which includes the health supervision of individuals and families as well as nursing the sick in the home or hospital.

A point of view from America was: An understanding of the science of psychology should be a part of the basic education of every good nurse. A school of nursing should aim to produce nurses who understand people and who know how to meet the problems inherent in their profession. The complaints about nurses today are not that they do not recognize symptoms, but that they cannot get along with people. They may be able to take temperature, pulse, and respiration but they cannot adapt themselves to changing situations. They may be able to give treatments properly but their personalities are not acceptable to their patients. "Psychology and psychiatry are the warp and woof of the general nursing curriculum."

There was not such unanimity over the inclusion of maternity nursing in the general nursing education. No doubt this is due to the varying customs in different countries as to the profession of midwifery. Where midwifery requires a long period of training, making it difficult for the general nurse to take the extra course, it has become a specialized profession completely divorced from nursing. In other countries there is the desire for midwifery to be a part of the equipment of every nurse. They believe that since antenatal and maternity work should be the beginning of all public health work, training in these and in the "first-aid" of midwifery should be required of every nurse.

Another subject of interest to public health nurses was the relation of social service to public health nursing. It was the opinion of Finland's speaker that in rural areas the social worker and the public health nurse should be the same person, as no line of demarcation could be drawn between their duties; that social service should find a place in every nurse's preparation. In England the position seemed to be that since so high a percentage of the country was industrialized, there was of necessity a division of labor between the health services and social work.

The Queens Institute of District Nursing—in a session devoted to the work of this great organization which is celebrating the Jubilee anniversary of its founding—described its activities as the national body for the training of district nurses and the supervision of district nursing in Great Britain. Writing in 1878 of the work of Institute, Florence Nightingale said "You have a glorious future if you keep your standard high."

NURSING IN INDUSTRY

So new a subject as industrial nursing attracted a large audience when the history of this branch of the profession which was born in Great Britain in 1878, was described. Nurses are now to be found in both commercial and industrial life, in institutions ranging from factories to hotels and insurance offices to retail stores or banks. The appeal

supported by a discussion from Germany, was for a broader interpretation to be put upon the term *industrial nursing*. Gone should be the days when the nurse was employed only for the purpose of binding up the damaged limb. Her outlook should be always how to prevent those accidents or those illnesses which caused so much absenteeism and loss of wealth to the community. The future of this work rests mainly in the hands of the nurses themselves. They have it in their power to create a service which will be sought for by industry because of the foundations of practical common sense, understanding, and good judgment on which their work is based.

The President, Dame Alicia Lloyd Still, The Matron of St. Thomas' Hospital graciously presided over the general sessions. In her welcome she said, "Friends and fellow nurses from the world over, nursing is an art. The best powers of mind and heart should be given to enrich and ennoble that art. We are in danger of making a study of nursing instead of an informed and skilled practice of nursing. We need both science and art, but it must be applied science and practical art. Do not let us be in a great hurry to make reforms. Take time. Go slowly. It may be months, it may be years before we attain our object. But if those months and those years have within them all our concentrated effort, all our best thought, then will they be worth passing on to the future generations."

At the general sessions when the new countries were welcomed into the membership of the International Council of Nurses, and over which Mrs. Bedford Fenwick presided, Sir George Newman, until recently Chief Medical Officer of the Ministry of Health, delivered the first Florence Nightingale oration. His audience of over 3000 nurses were spellbound as he unfolded the romance of Florence Nightingale's life. Striking sentences from his speech were, "Miss Nightingale was self-renouncing because self-dedicated. Emulate her, do not imitate her. Do not let the dead hand of the past hinder you. None of her great objects were entirely achieved in her time. She only started them; it is for us to complete them. And in this task we should be greatly helped if each nation could eliminate its own traditional lack of appreciation of other nations, for to know each other and to understand each other is always to make juster judgments of each other."

Space will not allow a description of the many social functions which were so lavishly provided for the guests. The ancient Guild Hall, the center of London's romantic city, complete with Lord and Lady Mayoress, priceless gold plate, and all the scarlet robes of the Aldermen, opened its famous halls. The Government welcomed the delegates to the House of Lords, and the hospitals entertained in their historic board rooms. Among other parties, the Public Health Section of the College of Nursing arranged a charming ballet under the trees of Bedford College for Women. This College has for many years welcomed the public health nurse as a student, and is the college chosen for the international courses which are the responsibility of the Florence Nightingale International Foundation.

And so night after night, London provided unending opportunities for the renewal of friendships, for the finishing of discussions and arguments which were perhaps commenced in Paris and Brussels in 1934 and will no doubt be continued with renewed determination when we go to America in 1941.

Census of Public Health Nurses 1937

ACCORDING to the report, "Total Number of Nurses Engaged in Public Health Work in the United States, Hawaii, and Alaska on January 1, 1937," there were 21,656 full-time public health nurses in that area.* The Census of Public Health Nursing of January 15, 1931, made by the National Organization for Public Health Nursing, showed that the total number of public health nurses in the United States, exclusive of industrial nurses, was 15,915 at that time. For comparison, deducting the 1717 WPA nurses, the 145 nurses in Hawaii and Alaska—which territories were not included in the earlier total—and the 2179 industrial nurses in the United States from the 1937 total of 21,656, we have a total of 17,615 in 1937 as compared with 15,915 in 1931. The increase since 1931 is 1700 nurses, or 10.7 percent. The table which follows shows the distribution by employing agency in 1931 and 1937. In both years nurses employed only for social service or dispensary work are excluded.

TABLE I

NUMBER OF FULL-TIME PUBLIC HEALTH NURSES IN THE UNITED STATES—1931 AND 1937

Employing agency	Jan. 15, 1931[1]	Jan. 1, 1937[2]
Federal agencies[3]	*82*	*74*
Official	20	18
Non-official	62	56
Official federal allocated to local areas:		
Indian Service	*76*	*108*
Other	*115*	—
State agencies[4]	*407*	*773*
Official	326	773
Health departments	318	684
Boards of education	5	19
Other official	3	70
Non-official	81	—[5]
Public health nursing departments of universities and colleges	*24*	*31*
Local agencies[4]	*15,211*	*16,629*
Official	9,098	10,859
Health departments	5,309	6,083
Boards of education	2,980	3,470
Other official	809	1,306
Non-official	6,024	5,770
Visiting nurse, Red Cross, tuberculosis association	4,487	4,627
Life insurance companies	535	544
Other non-official	1,002	599
Joint official and non-official	89	—[6]
Total	*15,915*	*17,615*

[1] Exclusive of 3189 industrial nurses.

[2] Exclusive of 2179 industrial nurses and 1717 WPA nurses.

[3] Includes only public health nurses employed by federal or other national agencies, who serve more than one state; others included with local count.

[4] State-paid nurses who render direct field service on an itinerant basis are counted as state employees; state-paid nurses who are assigned to a local area for full-time service are counted as local employees.

[5] Seven nurses who were employed by state non-official agencies performed local services and were allocated to local associations.

[6] Where a number of local agencies contribute to the support of a service, the nurses are credited to the agency expending the most funds.

*Data collected by the Public Health Nursing Consultants of the U. S. Public Health Service and the U. S. Children's Bureau, through the respective state health departments. Mimeographed reports B-2051 and B-2043. Available from U. S. Public Health Service, Washington, D. C.

The change in total number of public health nurses employed in each of the states and the District of Columbia since 1931 is given in Table II.

TABLE II

NUMBER OF FULL-TIME PUBLIC HEALTH NURSES IN EACH STATE[1]—1931 AND 1937

	No. of public health nurses		Change since 1931			
			Increase		Decrease	
	Jan. 15, 1931	Jan. 1, 1937	No.	Percent	No.	Percent
Alabama	141	149	8	5.7		
Arizona	53	101	48	90.5		
Arkansas	72	78	6	8.3		
California	865	1,031	166	19.2		
Colorado	125	146	21	16.8		
Connecticut	518	572	54	10.4		
Delaware	44	68	24	54.5		
District of Columbia	102	144	42	41.2		
Florida	95	135	40	42.1		
Georgia	151	209	58	38.4		
Idaho	28	46	18	64.3		
Illinois	919	932	13	1.4		
Indiana	342	371	29	8.5		
Iowa	190	219	29	15.3		
Kansas	133	139	6	4.5		
Kentucky	175	277	102	58.3		
Louisiana	105	132	27	25.7		
Maine	123	124	1	.8		
Maryland	265	291	26	9.8		
Massachusetts	1,156	1,189	33	2.9		
Michigan	893	960	67	7.5		
Minnesota	352	414	62	17.6		
Mississippi	39	113	74	190.0		
Missouri	373	346			27	7.2
Montana	54	64	10	18.5		
Nebraska	90	70			20	22.2
Nevada	9	19	10	111.1		
New Hampshire	142	157	15	10.6		
New Jersey	1,033	950			83	8.0
New Mexico	24	75	51	212.5		
New York	2,665	3,135	470	17.6		
North Carolina	174	190	16	9.2		
North Dakota	24	35	11	45.8		
Ohio	977	1,066	89	9.1		
Oklahoma	66	89	23	34.9		
Oregon	99	103	4	4.0		
Pennsylvania	1,499	1,380			119	7.9
Rhode Island	194	208	14	7.2		
South Carolina	80	138	58	72.5		
South Dakota	26	58	32	123.0		
Tennessee	211	234	23	10.9		
Texas	231	214			17	7.4
Utah	38	89	51	134.0		
Vermont	52	54	2	3.8		
Virginia	234	243	9	3.8		
Washington	139	196	57	41.0		
West Virginia	104	135	31	29.8		
Wisconsin	371	401	30	8.1		
Wyoming	14	21	7	50.0		
Total	15,809	17,510	1,701	10.8		

[1] Exclusive of industrial nurses, nurses who serve more than one state, and nurses employed as instructors in universities and colleges.

There has been an increase in all but the five states of Missouri, Nebraska, New Jersey, Pennsylvania, and Texas. In New York State the largest number of nurses has been added—470, the next largest number being in California. The greatest percent increase has occurred in New Mexico. An analysis of change in number of public health nurses, grouping the states into the five districts used in the 1937 census, indicates that the greatest percent increase has occurred in the Western and South Atlantic districts (30.6% and 24.3% respectively), and the least in the Northeastern and North Central districts.

TABLE III

NUMBER OF PUBLIC HEALTH NURSES IN EACH OF FIVE DISTRICTS[1]—1931 AND 1937

District	Number of public health nurses 1931	1937	Increase No.	Percent
I. Northeastern Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont	7,382	7,769	387	5.2
II. South Atlantic Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia	1,249	1,553	304	24.3
III. North Central Illinois, Indiana, Iowa, Michigan, Minnesota, Nebraska, North Dakota, Ohio, South Dakota, Wisconsin	4,184	4,526	342	8.2
IV. South Central Alabama, Arkansas, Kansas, Kentucky, Louisiana, Mississippi, Missouri, Oklahoma, Tennessee, Texas	1,546	1,771	225	14.6
V. Western[2] Arizona, California, Colorado, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming	1,448	1,891	443	30.6
Total	15,809	17,510	1,701	10.8

[1] Exclusive of industrial nurses, nurses who serve more than one state, and nurses employed as instructors in universities and colleges.

[2] Western District includes also Alaska and Hawaii as defined by the U. S. Public Health Service and the U. S. Children's Bureau. These areas are excluded from this table and those which follow.

The changes in the numbers of nurses employed by official and non-official agencies are shown in Table IV, which follows.

TABLE IV

PUBLIC HEALTH NURSES EMPLOYED BY OFFICIAL AND BY NON-OFFICIAL AGENCIES 1931 AND 1937

Agencies	1931 Number	Percent	1937 Number	Percent
Official	9,724[1]	61.2	11,758	66.9
Non-official	6,167	38.8	5,826	33.1
Total	15,891[2]	100.0	17,584[2]	100.0

[1] *Official* includes joint official and non-official administration.

[2] Exclusive of industrial nurses and nurses in public health nursing departments of universities and colleges.

There has been an increase of 2034 nurses employed by official agencies or a 21% increase;* and a decrease of 341 nurses, or a 6% decrease, in the number employed by the non-official agencies. The distribution in 1937 is two-thirds employed by the former group and one-third by the latter. The variation in the percent of nurses employed by the official agencies for different sections of the country is shown in Table V, using the five districts as defined above. This percentage is least in the Northeastern district (58%) and highest for the Western (86%), the two areas respectively in which the lowest and highest percent increase in total number of public health nurses employed was found.

TABLE V

PERCENT OF TOTAL PUBLIC HEALTH NURSES IN EACH OF FIVE DISTRICTS EMPLOYED IN OFFICIAL AGENCIES—1937

District	Total nurses	Employed in official agencies	
		Number	Percent
I. Northeastern	7,769	4,313	55.5
II. South Atlantic	1,553	1,156	74.4
III. North Central	4,526	3,243	71.6
IV. South Central	1,771	1,405	79.3
V. Western	1,891	1,623	85.8
Total	17,510[1]	11,740[1]	

[1] Exclusive of industrial nurses, nurses who serve more than one state, and nurses in universities and colleges.

Table VI shows the approximate population per nurse in each of the five areas in 1931 and in 1937, based on the figures of the 1930 census.

TABLE VI

APPROXIMATE POPULATION PER NURSE IN EACH OF FIVE DISTRICTS—1931 AND 1937

District	Population 1930 census	Approx. pop. per nurse	
		1931	1937
I. Northeastern	34,426,000	5,000	4,000
II. South Atlantic	15,794,000	13,000	10,000
III. North Central	33,085,000	8,000	7,000
IV. South Central	27,575,000	18,000	16,000
V. Western	11,897,000	8,000	6,000
Total	122,777,000	8,000	7,000

The approximate population per nurse for the country as a whole was 8000 in 1931 and 7000 in 1937, based on the 1930 population census. In both years this ratio was lowest for the Northeastern district. The South Atlantic and South Central districts were highest in 1931, and are in 1937. The Western district, in which the greatest percent increase in number of nurses employed occurred (Table III) has next to the smallest ratio.

In the two districts with the highest ratio of population to number of nurses, the South Atlantic and South Central, the rural population is 71% and 73% respectively of the total population. In the Northeastern district where the ratio is smallest, this percent is 31.

Table VII shows the distribution of

* Personnel Policies in Public Health Nursing, a Report of Current Practice in a Sample of Official Health Agencies in the United States, by Marian G. Randall, includes a census of public health nurses employed by official agencies in 1936, which shows an increase of 23% since 1931.

numbers of urban and rural nurses and the urban and rural population in 1931 and 1937 for the country as a whole.

TABLE VII
URBAN AND RURAL NURSES[1]—1931 AND 1937

	Population 1930		Public health nurses[2] 1931		1937	
	Number	Percent	No.	Percent	No.	Percent
Urban	58,336,000	47.5	11,290	71.4	11,559	66.0
Rural	64,441,000	52.5	4,519	28.6	5,951	34.0
Total	122,777,000	100.0	15,809	100.0	17,510	100.0

[1] Data from supplementary tables furnished by the U. S. Public Health Service.
[2] Exclusive of industrial nurses, nurses who serve more than one state, and nurses in universities and colleges.

The rural figures in this table are based on the definition of *rural* adopted in the 1937 census made by the U. S. Public Health Service and the U. S. Children's Bureau, which is as follows: "Rural areas include the open country and places having a population of less than 10,000. All state employees are counted as rural."

Table VII shows that one third of the total number of public health nurses are rural nurses, while one half of the population falls into this category as defined previously. In 1931 the rural nurses constituted about one fourth of the total number. The percent increase in the number of rural nurses since 1931 was 32; for urban it was only 2. The population per urban nurse was, therefore, the same in both years—5000. For the rural nurse this number decreased from 14,000 to 11,000. See Table VIII.

TABLE VIII
APPROXIMATE POPULATION PER RURAL NURSE AND PER URBAN NURSE[1]—1931 AND 1937

District	Approx. rural population 1930 census	Number of rural nurses[2] Jan. 15, 1931	Jan. 1, 1937	Approx. population per rural nurse 1931	1937
I. Northeastern	10,729,000	1,825	2,202	6,000	5,000
II. South Atlantic	11,246,000	440	721	26,000	16,000
III. North Central	16,240,000	969	1,128	17,000	14,000
IV. South Central	20,093,000	640	915	31,000	22,000
V. Western	6,133,000	645	985	10,000	6,000
Total	64,441,000	4,519	5,951	14,000	11,000
	Approx. urban population	Number of urban nurses[2]		Approx. population per urban nurse	
I. Northeastern	23,697,000	5,557	5,567	4,000	4,000
II. South Atlantic	4,548,000	809	832	6,000	5,000
III. North Central	16,845,000	3,215	3,398	5,000	5,000
IV. South Central	7,482,000	906	856	8,000	9,000
V. Western	5,764,000	803	906	7,000	6,000
Total	58,336,000	11,290	11,559	5,000	5,000

[1] Data from supplementary tables furnished by the U. S. Public Health Service.
[2] Exclusive of industrial nurses, nurses who serve more than one state, and nurses in universities and colleges.

ANNA J. MILLER
Statistician, National Organization for Public Health Nursing

A Program for Staff Education

Pneumonia

By MARGARET REID, R.N.
Educational Director, Nursing Bureau, Welfare Division, Metropolitan Life Insurance Company, New York, N. Y.

Pneumonia is the third highest cause of death in the United States. Every nurse needs to be informed on this major problem in the field of public health today

PNEUMONIA kills more people than does any other disease, except heart disease and cancer. It is third on the list of the principal causes of death in the United States. All forms of pneumonia and influenza together cause the death of 133,000 people a year in the United States, and over half of these deaths are due to lobar pneumonia. Reliable studies show us that approximately 50 percent of these deaths could be prevented if known sources of treatment were utilized. These known treatments are serum therapy and symptomatic treatment. For both, nursing care is essential, and yet we know that of all those dying from pneumonia probably 50 percent receive no skilled nursing care beyond that of concerned relatives and friends.

PREVENTABLE DEATHS

Just what do these facts mean to you and to your community? Who recalls a neighbor down the road or street—a handsome, strong-appearing man, who was just getting established in his own home after the depression, when he was suddenly stricken with a cold last winter, a cold that led to pneumonia and ended in death? His wife had to give up the little home and take a clerking job in a drug store. His boy had to give up his plan to go to college and go to work instead. That man should be alive today—and probably would be if he had called the doctor soon enough!

A pathetic, regrettable incident like this is probably one thing that these facts about pneumonia mean to you. But surely the thought that half the deaths now caused by pneumonia might be prevented does more than stir our emotions to a state of sympathy; it excites us to the point where we want to do something! What can we do?

First, we can find out what we do know and what we do not know about pneumonia, and do something about the part we do not know about.

Second, we can determine what the pneumonia situation is in our community.

Third, we can, insofar as we are able, join the state and local pneumonia control programs.

In this article we are concerned only with finding out what we do know or do not know about pneumonia. Let us get at this, then, through a few questions.

Etiology

What germs cause pneumonia?

What percentage of lobar pneumonia is pneumococcic?

Why should the doctor know the different types of pneumococcus?

Diagnosis

What is the Neufeld method of typing?

Why has this sputum-typing method produced such a profound effect upon the treatment of pneumonia?

When, during the course of the disease, does the doctor want to type sputum?

From what part of the throat is sputum collected for typing and why?

To what extremes should one go to secure sputum?

Why is a blood culture taken and when is it taken?

Serum therapy

What factors are essential for successful treatment by serum?

How is serum administered?

What precautions must be taken in the administration of serum?

How many doses of serum are given?

Should syringes and needles used in giving serum be wet- or dry-sterilized?

What percent of patients treated with serum have allergic reactions?

What percent have chill reactions?

Is serum used in the treatment of bronchopneumonia?

What is the significance of bacteremia in pneumonia?

Symptomatic treatment

Is there anything new in the symptomatic treatment of pneumonia?

When is oxygen therapy resorted to in the treatment of pneumonia?

What methods for giving oxygen are generally accepted by medical authorities?

Are there dangers attending oxygen therapy? What are they?

What responsibilities has the nurse in the administration of oxygen?

Field of research

Have you heard of Hydroxyethlopocupreine?

Do you know of the research in the field of chemotherapy in the treatment of pneumonia?

Communicability

Are there carriers of pneumonia? If so, how significant are they in the epidemiology of pneumonia?

Is contact the only factor necessary to the spread of pneumonia?

Prevention

Is there a pneumonia vaccine?

It will not be surprising if you are not sure of the answers to most of these questions, but they represent only a few of the questions regarding pneumonia that all of us engaged in public health nursing should be able to answer. That means we have a problem of learning on our hands. Just how shall we go about it? Are there any short cuts? I believe a staff educational program on pneumonia is the solution. The following suggestions are made for a large staff. Nurses working on a small staff or alone, however, will find direction in them for individual study and activity.

The program can center around activities on the one hand and study on the other. Several weeks may be spent in project activities and study by small groups who, later, will relay the information secured to the staff as a whole. Perhaps in a concluding meeting, a symposium or a panel discussion* might be held covering the general question, "What are the major responsibilities of the nurse with respect to the problem of pneumonia control?"

*Fansler, Thomas. Discussion Methods for Adult Groups; Case Studies of the Forum, the Discussion Group, and the Panel. American Association for Adult Education, 60 East 42 Street, New York, N. Y. 1934.

SUGGESTIONS FOR A STAFF PROGRAM FOR THE STUDY OF PNEUMONIA

EDUCATIONAL PROJECTS OR ACTIVITIES

Interest may be stimulated in the members of a project group by permitting the nurses to choose their projects.

I. CHART MAKING

A. Charts depicting the incidence and distribution of pneumonia in the United States, the state, and the local community

B. Charts depicting pneumonia mortality rates by geographic location, race, occupation, and by sex and age groups

C. Charts depicting case fatality rates and estimated case fatality rates with serum therapy

II. INVESTIGATION OF LOCAL FACILITIES

A. The hospital facilities for the care of pneumonia patients

B. Availability of nursing service
   1. In hospitals
   2. In homes
      a. Private duty through registries
      b. Public health nursing services which give bedside care

C. Laboratory resources
   1. For blood culturing
   2. For sputum typing
   3. For provision of serum

D. Treatments used in hospitals and by physicians in private practice
   1. Serum therapy
   2. Oxygen therapy—methods of
   3. Stimulants
   4. Sedatives
   5. Counterirritants to relieve pleuritic pain
   6. Location of supplies of oxygen

III. SETTING UP DISPLAYS*

A. Equipment necessary to secure sputum for typing

B. Equipment necessary for securing blood for cultures and for administering serum

C. Equipment necessary for oxygen therapy for any or all of the following methods of administration
   1. Oxygen chamber
   2. Oxygen tent
   3. Nasal catheter, single or fork catheter

D. Exhibit of patient's room with patient in bed, illustrating important nursing procedures

E. Posters on clinical and bacteriological diagnosis

F. Reports on various state pneumonia control programs; that is, what the state and local community are doing

G. Exhibit of educational materials available for lay consumption, such as leaflets, and articles

*Displays such as these may be prepared by the nurses for use in their own staff conferences or for exhibit in the office or center. They may be used at nurses' meetings; at medical meetings, upon request; or in connection with exhibits of social agencies. The less technical ones are useful as educational materials for lay groups.

STUDY PROGRAM*

Possible units for group study:

I. ETIOLOGY AND PREVENTION—MEDICAL AND NURSING ASPECTS

A. Causative micro-organisms
B. Communicability
C. Source of infection
D. Predisposing factors
E. Preventive measures

II. DIAGNOSIS AND CLINICAL COURSE—MEDICAL AND NURSING ASPECTS

A. Diagnosis
   1. Clinical
   2. Bacteriological
      a. Sputum examination
      b. Blood cultures

*The outline for this study program was adapted from the Handbook on the Nursing Care of Pneumonia, prepared under the joint auspices of the Committee on Public Health and Medical Education of the Medical Society of the State of New York, the New York State Nurses' Association, the New York State Department of Health, the General Advisory Committee on Pneumonia Control of the New York State Department of Health, and the Nursing Advisory Committee to the Bureau of Pneumonia Control of the New York State Department of Health, and distributed without charge by the Metropolitan Life Insurance Company, 1 Madison Avenue, New York, N. Y.

B. Clinical course
   1. General appearance and condition
   2. Cough and sputum
      a. Frequency of medications
   3. Temperature
      a. Elevation extremes
   4. Pulse
      a. Frequency
      b. Character
      c. Cardiac stimulants
   5. Respirations
      a. Frequency
      b. Character
   6. Nature of recovery
      a. Character of crisis
      b. Character of lysis

III. SYMPTOMATIC TREATMENT—MEDICAL AND NURSING ASPECTS

A. Pleurisy
   1. Incidence
   2. Intensity
   3. Why serious
B. Distention
   1. When encountered
   2. Prevention
   3. Treatment
   4. Why serious
C. Rest
   1. Why important
   2. Control of insomnia and restlessness
   3. Delirium
      a. Cause and treatment
D. Nutrition
   1. Anorexia
   2. Importance of diet and caloric intake
E. Elimination
   1. Urine
   2. Bowels
   3. Skin

IV. SPECIFIC SERUM TREATMENT—MEDICAL AND NURSING ASPECTS

A. Antipneumococcus serum available
B. Technique of administration
   1. Typing
   2. The efficacy of serum treatment
   3. Tests for sensitivity to horse serum and history of allergic reactions
   4. Temperature of serum
   5. Epinephrine—need for
C. Serum reactions
   1. Acute anaphylactic
      a. Frequency
      b. Time of occurrence
      c. Manifestations
      d. Seriousness of
   2. Thermal reactions
      a. Time of occurrence
      b. The principal manifestation
      c. Seriousness of
   3. Delayed serum sickness
      a. Time of occurrence
      b. Manifestations
      c. Duration
D. Effects of serum treatment

V. OXYGEN TREATMENT—MEDICAL AND NURSING ASPECTS

A. Indications
   1. Anoxemia
B. Objective manifestations indicating oxygen therapy
C. Methods of oxygen administration
D. Continuity of oxygen therapy

VI. COMPLICATIONS, PROGNOSIS, AND CONVALESCENCE—MEDICAL AND NURSING ASPECTS

A. Complications
   1. During illness
   2. At the termination of the illness
   3. Rare complications
B. Prognosis
   1. Factors materially altering the outlook in any given case
C. Convalescence

Different staffs will go about securing this information in various ways according to the availability of lecturers, literature, and other sources of material on the subject. Since a bibliography is one of the important guides to such sources, a rather extensive one is appended in the hope that nurses everywhere will be able to locate some of the books and magazines in their local medical and nursing libraries.

Where there are hospital libraries, medical society libraries, or libraries of state departments of health, the librarians will gladly extend their facilities to nurses.

The first section of the bibliography consists of fairly available material, much of it in reprint form and much of it free; most of these publications may be had at a very low cost. The mate-

rials in the second section may not be as readily available; it is composed of interesting articles appearing in 1937 periodicals, representing current research in the field of pneumonia.

REFERENCES

The following references are fairly available and many of them are inexpensive or free materials:

I. Books

Bower, A. G., and Pilant, E. B. Communicable Diseases for Nurses. W. B. Saunders Company, Philadelphia, third edition reset, 1935.

Cecil, R. L. A Textbook of Medicine. W. B. Saunders Company, Philadelphia, fourth edition, 1937.

Harmer, Bertha. Textbook of the Principles and Practices of Nursing. The Macmillan Company, New York, third edition, revised, 1934.

Houston, W. R. The Art of Treatment. (Lobar Pneumonia, p. 149). The Macmillan Company, New York, 1936.

Howard, C. P. The Diagnosis and Treatment of Pneumonia. Oxford Monographs on Diagnosis and Treatment, Volume X. Oxford University Press, New York, 1936.

Lord, F. T., and Heffron, Roderick. Lobar Pneumonia and Serum Therapy. The Commonwealth Fund, New York, 1936.

National Organization for Public Health Nursing. Manual of Public Health Nursing. The Macmillan Company, New York, second edition, 1932.

New York State Department of Health. Handbook on the Nursing Care of Pneumonia. Circular 19 issued by the Bureau of Pneumonia Control, Division of Communicable Diseases and Division of Public Health Nursing, Albany, 1936. (May be secured from the Metropolitan Life Insurance Company, 1 Madison Avenue, New York, N. Y.)

Olson, L. M. Improvised Equipment in Home Care of the Sick. W. B. Saunders Company, Philadelphia, second edition, 1933.

Smith, Martha Ruth, and Broadhurst, Jean. An Introduction to the Principles of Nursing Care. J. B. Lippincott Company, Philadelphia, 1937.

Stimson, P. M. A Manual of the Common Contagious Diseases. Lea and Febiger, Philadelphia, 1936.

II. Magazines

American Journal of Nursing

Covi, R. E. "Case Study of Lobar Pneumonia." February 1936, p. 185.

Finland, Maxwell. "The Modern Treatment of Pneumonia." January 1936, p. 24.

Schukar, Madeline. "Mustard Packs in the Treatment of Pneumonia." February 1934, p. 110.

American Journal of Public Health

Rogers, E. S. "The New York State Program for the Control of Pneumococcus Pneumonia." February 1937, p. 133.

Cole, Rufus. "Recent Advances in the Control of Pneumonia." December 1936, p. 1191.

Journal of the American Medical Association

Cecil, R. L. "Effects of Very Early Serum Treatment in Pneumococcus Type I Pneumonia." February 27, 1937, p. 689.

Crewe, J. E. "Bringing Outside Air Inside, an Inexpensive Substitute for Oxygen Therapy." October 3, 1936, p. 1125.

Horsfall, F. L., Jr., and others. "Antipneumococcus Rabbit Serum as a Therapeutic Agent in Lobar Pneumonia." May 1, 1937, p. 1483.

New York Academy of Medicine, Committee on Public Relations. "Oxygen Administration." June 20, 1936, p. 2188.

Smillie, W. G. "The Epidemiology of Lobar Pneumonia." October 21, 1933, p. 1281.

New England Journal of Medicine

Burgess, A. M. "Oxygen Therapy—A Modification of the Box Method for Giving 95 Percent Oxygen." March 18, 1937, p. 467.

Finland, Maxwell. "Some Aspects of Pneumococcus Infection in Man." March 18, 1937, p. 460.

Robinson, E. S. "The Antiserum Treatment of Pneumonia from the Standpoint of Public Health." March 18, 1937, p. 459.

New York State Journal of Medicine

Bullowa, J. G. M. "Serum Therapy for Pneumococcus Type I Pneumonia." April 15, 1937, p. 723.

Cecil, R. L. "A Campaign to Reduce the Death Rate of Pneumonia in New York State." November 15, 1935, p. 1123.

Ellenberg, S. L., and Martin, A. T. "Lobar Pneumonia in Childhood—a Five and a Half

Year Clinical Survey at a Municipal Hospital." January 15, 1937, p. 119.

Public Health Nursing

Anderson, G. W., and Heffron, Roderick. "Present Status of Pneumonia Problem." December 1935, p. 633.

Sargent, E. G. "Detroit's Pneumonia Nursing Campaign." April 1935, p. 190.

Sheahan, M. W. "The Nurse in Pneumonia Control." December 1936, p. 802.

III. Federal and State Reports

Commonhealth, Massachusetts Department of Public Health

Heffron, Roderick, and Robinson, E. S. "Final Report of the Massachusetts Pneumonia Study and Service 1931-1935." January-February-March 1937, entire issue.

Quarterly Bulletin, Louisiana State Board of Health

Louisiana State Board of Health. "Serum Treatment for Lobar Pneumonia." March 1937, p. 2.

Public Health Reports, United States Public Health Service

Rosenthal, S. M. "Studies in Chemotherapy —The Effect of P-Aminobenzene Sulphonamide on Pneumococci in Vitro." February 12, 1937, p. 192.

Rosenthal, S. M. "Studies in Chemotherapy; II. Chemotherapy of Experimental Pneumococcus Infections." January 8, 1937, p. 48.

Rosenthal, S. M. "Studies in Chemotherapy; IV. Comparative Studies of Sulphonamide Compounds in Experimental Pneumococcus, Streptococcus, and Meningococcus Infections." May 21, 1937, p. 662.

IV. Booklet

Metropolitan Life Insurance Company. Pneumonia Control. Metropolitan Life Insurance Company, New York, N. Y., 1937. A booklet containing charts on the incidence and distribution of pneumonia; its etiology and diagnosis, serum therapy, and prognosis; displayed in the scientific exhibits at the annual meetings of the American Medical Association, Canadian Medical Association, and others. 1937.

V. Leaflets—for popular distribution in behalf of lay education.

John Hancock Mutual Life Insurance Company. Preventing Pneumonia. John Hancock Mutual Life Insurance Company, Boston, Mass., 1932.

Metropolitan Life Insurance Company. Asking the Doctor About Pneumonia. Metropolitan Life Insurance Company, New York, N. Y.

Metropolitan Life Insurance Company. Colds, Influenza, Pneumonia. Metropolitan Life Insurance Company, New York, N. Y.

New York State Department of Health. Pneumonia. Circular 21. Pamphlet issued by Division of Communicable Diseases, Bureau of Pneumonia Control, Albany, N. Y.

Many city and state health departments have similar leaflets.

VI. Bulletins of the Federal, State, and Local Health Departments

Public Health Reports, issued weekly by the United States Public Health Service.
It contains (1) current information regarding the prevalence and geographic distribution of communicable diseases in the United States and of important communicable diseases throughout the world, (2) articles relating to the cause, prevention, and control of disease, (3) other pertinent information regarding sanitation and the conservation of the public health. Order from Superintendent of Documents, Washington, D. C.

Health bulletins, issued monthly by state departments of health. These bulletins usually include monthly reports on the incidence of disease in the state, cases of reportable diseases by locality, vital statistics, and deaths from important causes.

Many city and county health departments print similar bulletins; and if they do not print bulletins, health departments have the vital statistics available for anyone interested in securing specific information.

The following bibliography is a selected list of articles on pneumonia, appearing in current medical journals:

Arena, J. M. "Results of Blood Transfusions in Primary Pneumonia in Infants and in Children." *American Journal of Diseases of Children,* July 1937, p. 23.

Benjamin, J. E., and others. "A Study of the Diagnosis and Treatment of Lobar Pneumonia According to Types and Specific Serum Therapy." *Annals of Internal Medicine,* September 1937, p. 437.

Bortz, E. L. "Serum in the Treatment of Pneumonia." *Science,* April 23, 1937, p. 9.

Bullowa, J. G. M., and Greenbaum, Evelyn. "Pneumococcic Pneumonia in Infants and in Children." *American Journal of Diseases of Children,* January 1937, p. 22.

Bullowa, J. G. M., and Wilcox, Clare. "Endemic Pneumonia. Pneumococcic Types and Their Variations in Incidence and Mortality for Adults and Children." *Archives of Internal Medicine,* March 1937, p. 394.

Campbell, J. A. "For Oxygen Administration." *Modern Hospital,* February 1937, p. 90.

Finland, Maxwell, and others. "Infections with Pneumococcus Type VII." *American Journal of the Medical Sciences,* January 1937, p. 48.

Finland, Maxwell. "The Significance of Specific Pneumococcus Types in Disease, Including Types IV to XXXII (Cooper)." *Annals of Internal Medicine,* April 1937, p. 1531.

Finland, Maxwell, and Loverud, H. I. L. "Massive Atelectatic Collapse of the Lung Complicating Pneumococcus Pneumonia." *Annals of Internal Medicine,* June 1937, p. 1828.

Finland, Maxwell, and Tilghman, R. C. "Bacteriological and Immunological Studies in Families with Pneumococcic Infections: the Development of Type-Specific Antibodies in Healthy Contact Carriers." *Journal of Clinical Investigation,* September 1936, p. 501.

Gunther, Lewis, and Blond, H. H. "Observations on the Use of Carbon Dioxide in Early Pneumonia." *American Journal of Medical Sciences,* April 1937, p. 525.

Harris, A. H., and Ingraham, H. S. "A Study of the Carrier Condition Associated with Type II Pneumonia in a Camp of the Civilian Conservation Corps." *Journal of Clinical Investigation,* January 1937, p. 41.

Heintzelman, J. H. L., Hadley, P. B., and Mellon, R. R. "The use of P-Aminobenzenesulphonamide in Type 3 Pneumococcus Pneumonia." *American Journal of the Medical Sciences,* June 1937, p. 759.

Irving, Peter. "Reduction of Mortality from Pneumococcus Pneumonia." *Preventive Medicine,* February 1937, p. 8.

Kaltreider, N. L., and others. "Pulmonary Capacity in Lobar Pneumonia with Special Reference to Collapse Therapy." *Archives of Internal Medicine,* March 1937, p. 408.

Kohn, J. L., and Weiner, S. B. "Pneumonia in Children." *American Journal of Diseases of Children,* May 1936, p. 1095.

Locke, Arthur. "Lack of Fitness as Predisposing Factor in Infections of the Type Encountered in Pneumonia and in Common Cold." *Journal of Infectious Diseases,* January-February 1937, p. 106.

Maclachlan, W. W. G. "The Problem of Chemo-Therapy in Pneumonia." *Scientific Monthly,* August 1937, p. 105.

Maclachlan, W. W. G. "Chemical Promises to Reduce Pneumonia Deaths to Half." *Science News Letter,* May 15, 1937, p. 307.

Moersch, H. J. "Oxygen Therapy in the Treatment of Pneumonia." *Proceedings of the Staff Meetings of the Mayo Clinic,* January 20, 1937, p. 33.

Painton, J. F., and Ulrich, H. J. "Lobar Pneumonia; An Analysis of 1298 Cases." *Annals of Internal Medicine,* March 1937, p. 1345.

Park, W. H. "Serum Typing to Discover the Type of Pneumococcus Causing Pneumonia." *Preventive Medicine,* May 1937, p. 39.

Reimann, H. A. "Infectious Diseases." Review of Current Literature. *Archives of Internal Medicine,* August 1937. (Pneumonia, p. 337-346.)

Smillie, W. G. "A Study of an Outbreak of Type II Pneumococcus Pneumonia in the Veterans' Administration Hospital at Bedford, Massachusetts." *American Journal of Hygiene,* November 1936, p. 522.

Tilghman, R. C., and Finland, Maxwell. "Pneumococcic Infections in Families." *Journal of Clinical Investigation,* September 1936, p. 493.

Tilghman, R. C., and Finland, Maxwell. "Clinical Significance of Bacteremia in Pneumococcic Pneumonia." *Archives of Internal Medicine,* April 1937, p. 602.

Wilson, J. A., and Carey, W. C. "Further Observations in Parenteral Liver Extract Therapy in Pneumonia." *American Journal of the Medical Sciences,* June 1937, p. 752.

The A.P.H.A. and the N.O.P.H.N.

NEW YORK CITY became the Mecca for public health nurses from far and near as the American Public Health Association and the National Organization for Public Health Nursing met jointly for the first time in their history, October 4-8. Newcomers to the great city had the thrill of a first visit to the Statue of Liberty, the Bowery, Greenwich Village, Harlem, and Central Park, sandwiched in between meetings and interesting trips to the city's many health agencies. Oldtimers spent their between-hours in reunions with friends, revisits to old haunts of their former work or study, and perhaps a matinee or a dinner at some favorite eating place.

Certain beneficial results of the joint meeting seemed evident to those attending the sessions. Many more public health nurses were present than usually attend the A.P.H.A. meeting. The various groups of health workers were brought closer together by a discussion of their common interests. And the problems of public health nursing were more closely interwoven into all the meetings, as the many activities in which nurses participate were discussed.

The outstanding event of the week to N.O.P.H.N. members was the Silver Jubilee banquet held in honor of the organization's 25th anniversary, at which Dr. Thomas Parran gave a stirring address.*

The health education institute, which was attended by many public health nurses, and the public health education sessions were most stimulating. Especially provocative was the panel discussion, "Can Health Education Be Evaluated?" A particularly lively session was the one on health education publications and window displays, including clinics on printed matter and posters. The comments on posters were interesting. Dr. H. E. Kleinschmidt brought out the difference between wall charts and posters: that since a wall chart is informational in purpose and meant to be studied, it may contain several ideas and some details; whereas a poster, which is meant to be taken in at a passing glance, should be simple, without detail, conveying only a single idea. Dr. William W. Bauer brought out the fact that the accuracy of content of health posters has improved tremendously during the past ten years. No longer do posters contain such legends as "A clean tooth never decays"; exaggerated, inaccurate statements used for emphasis have disappeared.

Interesting to school nurses was the paper on a new method of screening children with malnutrition, by means of periodic weighing, "The Extent and Seasonal Variation of Intermittency in Growth," by Dr. Clair E. Turner; also, "The Screening of Behavior Disorders in School Children," by Dr. Max Seham. Out of several outstanding discussions on the crippled child, we select for special mention Dorothy J. Carter's paper on "The Public Health Nurse and Orthopedic Nursing Care."

The report by Marian G. Randall on the N.O.P.H.N. "Study of Personnel Practices for Public Health Nurses in Official Agencies" was received with great interest. This report is to be published by The Macmillan Company.

A new concept was the idea of a health coördinator working jointly for the health department and the board of education, a plan now being tried out in Tennessee, which was described by Dr. Harold H. Walker, Associate Professor of Public Health Education at the University of Tennessee.

Educational and entertaining was a

(*Continued on advertising page 5*)

*See page 661 for a description of the N.O.P.H.N. events; page 617 for Dr. Parran's address.

NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

AT THE N.O.P.H.N.—A.P.H.A. MEETING

The Roof Garden of the Pennsylvania Hotel was the scene of the N.O.P.H.N. Silver Jubilee banquet on October 4, during the joint meeting of the N.O.P.H.N. with the American Public Health Association. Almost 500 people attended the dinner, at which Henry Bruere of New York City, Chairman of the National Jubilee Committee, presided. Dr. Thomas Parran, Surgeon General of the U. S. Public Health Service, gave the address of the evening, "Public Health Nursing Marches On." (See page 617.) Greetings were extended by Amelia Grant, President of the N.O.P.H.N., Dr. John L. Rice, Health Commissioner of New York City, Sir Arthur Newsholme, formerly Principal Medical Officer of Health of the Local Government Board of England, and Mary Beard, Associate Director of the International Health Division, Rockefeller Foundation, and a former president of the N.O.P.H.N.

A colorful pageant on the history of nursing was presented, with Mrs. Anne L. Hansen, Director of the Visiting Nurse Association, Buffalo, New York, reading the script.* Nurses in quaint old-time costumes as well as modern uniforms, depicting highlights in the history of nursing paraded slowly through the banquet hall as Mrs. Hansen described the place of each in history—from Fabiola to the student nurse of today.** The cast was drawn largely from the staffs of local agencies doing public health nursing in New York City.

N.O.P.H.N. state membership representatives held a luncheon meeting of their very own for the first time on October 4, with 20 people present, representing the following states: Arkansas, Florida, Illinois, Kentucky, Missouri, New York, Massachusetts, North Dakota, Virginia, and West Virginia. They discussed membership figures for the Jubilee Year—9602 individual members, of which more than 2000 joined this year for the first time; 21 new life members; and 20 new agency members —and discussed plans for 1938.

Other N.O.P.H.N. committees which met during the week were: the Committee to Study the Functions of the N.O.P.H.N., the Education Committee, the Organization Committee, the Joint Committee to Study Vocational Service, and the Council of Course Directors. There was also a joint meeting of the state directors of public health nursing and instructors in public health nursing.

The N.O.P.H.N. had a booth at the meeting, with an educational display of bags from the Department of Health, the Lobenstine Clinic, the Henry Street Visiting Nurse Service, and the Association for Improving the Condition of the Poor—all in New York City. Staff

*The pageant, which has been previously produced at two New York state meetings, was published in the October number, page 567. In response to questions raised by our readers regarding the "first regular training school for nurses" in the United States: the New York Hospital "made the first attempt to teach its nurse attendants" (1798); Linda Richards, from the New England Hospital for Women and Children, received her certificate as "the first trained nurse in the United States" (1873). (Nutting and Dock.) The first nursing school "to be organized definitely on Nightingale lines, was at Bellevue Hospital, New York City" (1873). (Dock and Stewart.)

**The costumes for such outstanding characters as Frederike Fliedner, Florence Nightingale, the Professor of Nursing, Sairy Gamp, and many of the uniforms of the early schools of nursing were generously lent by Mr. John Olsen, Superintendent of Richmond Memorial Hospital, Staten Island, New York. The modern costumes were obtained from local agencies.

nurses from the following agencies in the vicinity of New York City assisted in interpreting the contents of the bags to visitors: Public Health Nursing Organization of Eastchester, Inc., Tuckahoe, N. Y., the Visiting Nurse Association of the Oranges and Maplewood, Orange, N. J., and Public Health Nursing, Out-Patient Department, Englewood Hospital Association, Englewood, N. J.

NEW HANDBOOK AVAILABLE

A new handbook on records and the cost of a visit entitled, "Suggestions for Statistical Reporting and Cost Computation in Public Health Nursing" is now available from the N.O.P.H.N. at 25 cents a copy. It includes the most recent recommendations of the Records Committee and of the Service Evaluation Committee, and was prepared by a joint subcommittee of the two.

The publication illustrates the revised daily report form and a new monthly report form. It includes definitions of terms and instructions for the use of these forms, both of which can be obtained from Mead & Wheeler. The section on cost computation is a compilation of material on this subject from various sources, and facilitates reference to it.

WITH THE STAFF

All of the N.O.P.H.N. staff members participated in the A.P.H.A. Convention, some attending meetings and others taking charge of the N.O.P.H.N. exhibit.

Ruth Houlton went on an extensive field trip from October 11 to 22, attending state meetings in Terre Haute, Ind., Covington, Ky., Oklahoma City, Okla., and Little Rock, Ark. She also attended the meeting of the industrial nurses at the National Safety Congress in Kansas City, Mo., on October 13 and 14.

Ella McNeil has been released on six months leave of absence to participate in a school health study being carried on in selected suburban schools of New York City. (See September issue, page 553.)

The latter part of October, Virginia Jones attended state meetings in St. Louis, Mo., and Topeka, Kans.

Lulu St. Clair, Executive Secretary of the Joint Committee on Community Nursing Service for the three national nursing organizations, is still in the field. She attended state meetings in Nashville, Tenn., from October 10 to 13, and in Montgomery, Ala., October 18 and 19. She also made studies of the community nursing services in Blue Earth County and Duluth, Minn.

INVITATIONS TO 1940 BIENNIAL CONVENTION

Invitations from states to the 1940 Biennial Convention must be presented to the Convention Committee at least four months prior to the 1938 Biennial —that is, by January 1938. The following conditions must be complied with before the invitation can be considered:

1. Before a state or group of states issues an invitation to the three national nursing organizations to hold the Biennial Convention in a specified city, there must be written assurance in the form of an agreement drawn up and signed by the local chamber of commerce (or its representative for the administration of the auditorium or other responsible body or bodies) that facilities such as a convention hall, exhibit hall, and additional meeting places are available free of charge.
2. The nursing group in the state or states should indicate their willingness to coöperate in the undertaking.
3. Invitations must be endorsed by the three state organizations, where these exist.
4. The facilities offered by the city issuing the invitation should be carefully described, with the details in regard to such facilities, and they must meet with the approval of the Biennial Convention Committee.

For further information on the details to be checked, please write to the Chairman of the National Biennial Headquarters Committee, 50 West 50 Street, New York, New York.

YOU WANT A NURSE!

"PLEASE refer us a nurse," is a phrase now appearing much more frequently in incoming correspondence than even a year ago, and about twice to three times as often as when the depression struck rock bottom. It is always a very welcome request, but strange as it may seem, it is often unaccompanied by any informational data as to the professional dimensions needed to "fit the cloth to the pattern." Indeed, the organization letterhead may be the only guide.

The Joint Vocational Service is fortunate in having considerable data in its files on organizations and programs, and it has access to the N.O.P.H.N. files for information on specific situations. In order to give the kind of service the employer wants, there is needed as clear a picture as possible of the particular job to be filled.

J.V.S. has a form it likes to have employers use, when essential data is not presented in some other way. This form covers one page only and really should constitute no great chore to fill in. The important points are listed here in order to aid employers in knowing what should be included; the list will also suggest to nurses what information they need in order to decide whether they are interested in a given position. The employer does not always seem to understand that nurses designate preferences and restrictions when they register for work.

The minimal essentials of information we seek include a number of things beside the name and address of employing organization, the title of the position to be filled, and the name, title, and address of the person with whom to correspond. What date the position will be open; whether it is temporary or permanent; and if temporary, for how long —these are important. If the position is for a school nurse, how long is the school term? The annual rate of salary, and specific information on salary increases—if any—are most frequently omitted. Must the nurse own a car, or is full transportation or car maintenance provided? What qualifications does the employing agency require or prefer? Is the job under civil service rulings? To whom is the nurse to be responsible? Most important of all is a statement regarding the services which are included in the program of the organization and the responsibilities to be carried by the worker. Additional information such as the general character of the locale, and the financial status and proposed projects of the organization are of inestimable value in the search for suitable personnel to fill positions.

ANNA L. TITTMAN, R.N.
Vocational Secretary

JOINT VOCATIONAL SERVICE

reports that among its placements and assisted placements for September 1937 were the following:

PLACEMENTS

Sophie Fevold, Assistant Director, The Visiting Nurse Association, Dayton, Ohio.

Velma Pettiner, Director-Supervisor, District Nursing Association, Portland, Maine.

Lucile Gamble, Educational Director, Visiting Nurse Association, Milwaukee, Wis.

Pauline W. Mathewson, Director, Visiting Nurse Association, Burlington, Vt.

Mrs. Martha Hawkins Smith, Instructing Supervisor in Public Health Nursing, St. Luke's Hospital, Cleveland, Ohio.

Katharine Huff, Supervisor, Public Health and Visiting Nurse Association, Meriden, Conn.

Margaret Stockton and Mary Duane, Rural Health Nurses, State Department of Health, Albany, N. Y.

Dorothy Allen, Community Nurse, Mutual Aid Association, Brattleboro, Vt.

(Continued on advertising page 5)

COÖRDINATION OF HEALTH SERVICE AND PHYSICAL EDUCATION

HEALTH SERVICE and physical education are coördinates merely by reason of being units in the school program, though a working relationship may not exist. Used in the sense implied in the topic, to coördinate is to bring two or more units of the curriculum into harmonious relationship. Thus it is an administrative function. To be specific, it means analyzing health service and physical education to determine whether the greatest good will result from joint effort or from each keeping in its own channel. If the decision is in favor of joint effort, then the administrator, the head of the health service, and the director of physical education must decide upon a common program. Doing this is to achieve *coördination.*

Beyond this point, *coöperation* is the correct term. "Co" means together; thus we have operating or working together. It is joint action in which persons help one another to attain a common objective. It is teamwork. Coördination paves the way, by making coöperation possible. But in speaking of activities carried on jointly from day to day we are more correct to speak of coöperation.

To integrate is to go a step beyond coöperation. It means to make into one. Thus integration is the bringing together of parts into a whole. Although discussed often and hopefully in education, it is rarely achieved. Perhaps the best example is the union of spelling, grammar, reading, and composition to make a course in English. Health service and physical education, in spite of common elements, do not lend themselves to integration, though in a restricted sense it is accomplished when health service and physical education are placed under one administrative officer.

These two fields, however, lend themselves to coördination, because of their similarity of purpose. Upon analysis the two programs are found to have a common ground. Certain objectives of one are identical with those of the other.

WHY COÖRDINATE?

The question may be asked, why is coördination between two similar lines of activities desirable? It is desirable because, in the main, there is strength in union. Especially should this be true of the health services and physical education, because they have many factors in common. Each has much to contribute in support of the other.

Where there are two lines of activities headed toward the same goal, duplication is inevitable unless there is definite planning to avoid it. Coördination prevents this because in looking ahead we see the points of overlapping and re-

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Presented at the joint session of physical education teachers and nurses, State Teachers' Convention, Atlantic City, New Jersey, November 14, 1936.

move them. Hence, coördination is also economy, since it enables us to save in time, work, and cost.

Coördination tends to increase the personnel available for certain activities. Take a familiar example, athlete's foot. In one school the prevention and cure of this disease may be left to the health service staff, in another to the physical education staff. The results may be just as good in either case, but on the whole the work is more speedily and efficiently done where the two departments function together. In the first place, it permits a pooling of experience; second, it brings medical knowledge into the picture; third, it increases the number and frequency of possible contacts with pupils; and, fourth, it lightens the burden of work and responsibility.

In view of the above, we may state that the purpose of coördination is to bring health service and physical education into that reciprocal relationship which permits maximum coöperation in working toward common objectives.

PRINCIPLES OF COÖRDINATION

The term *principle* is used here as it is in education—that is, to mean a fundamental truth, a guide to program development and to activity. Certain principles are fundamental to effective coördination, and certain procedures will be necessary to carry out these principles. The principles, together with the procedures, are as follows:

1. The units to be coördinated should each have a program in writing. This eliminates guesswork. It permits, instead, the study of tangible factors and the discovery of those common to both programs. Each department, then, must develop its own program. Next, representatives of each must confer and agree upon like factors and objectives.

2. These factors common to both health service and physical education must be brought together to make a single core program. This is the common ground. When put into writing or in the form of a graph, both parties will have a definite picture of the ways in which they may coöperate.

3. There must be a working agreement, lest misunderstandings and difficulties arise to disrupt the whole project. In most instances, I believe the heads of the two departments can evolve a workable code and carry it out amicably for an indefinite period. In other places, differences in opinions and personalities will make coördination impossible, unless the school executive takes full charge.

By a working agreement, I mean that a definite understanding must be reached whereby each person will know in which situations he is to give orders, in which he is to obey orders, and in which he serves only in an advisory capacity.

4. There must be a willingness to coöperate. Lip service to something said to be desirable accomplishes precisely nothing. In coöperation it is action that gets results, but the persons acting must pull together and in the same direction.

5. There must be faith and trustworthiness. In a coöperative program, each individual or staff must have faith in the professional judgment of the other. By the same token, each must conscientiously strive to be worthy of the trust he expects the other to have in him.

AREAS OF COÖRDINATION

First, I will merely name the major areas in which coördination seems to be possible and desirable. Then I will give the principal methods by which coöperation takes place. Finally, I will try to bring both together: that is, the points of contact between the two programs and the measures of coöperation.

The areas of coördination are:

1. Health protection, meaning those activities which protect the pupil at school from communicable disease or from aggravation of existing ailments.

2. Health promotion, which covers

the educational phases of the joint program.

3. Prevention of injuries, including proper facilities and equipment and body conditioning.

4. Appraisal of pupil health, or such inventory devices as examinations, tests, and inspections.

5. Corrective measures, meaning all procedures introduced to cure or correct diseases and defects.

6. Sanitation.

METHODS OF COÖPERATION

The principal methods by which coöperation may take place are:

1. Interdepartmental conferences for planning program development, details of organization and administration, and technical procedures, and for determining policies.

2. Joint participation in certain activities which can best be carried out by physicians, dentists, nurses, physical education teachers, and others working together.

3. Regulations, meaning codes of rules relative to healthful conduct in physical education activities.

4. Instruction to pupils and faculty regarding various phases of the program. Health personnel from the different departments may coöperate in giving such instruction.

5. Standing orders. This term refers to orders laid down by the physician for the guidance of the nurse in the absence of the physician. As a method it is equally adaptable to the coöperative program, and standing orders may be given for the guidance of physical education teachers in certain situations involving the health protection of the child.

6. Records and reports. Under this heading there are two recommendations: (1) a uniform system of records; (2) a composite individual record serviceable alike to health service and physical education.

HOW COÖPERATION FUNCTIONS

Now I shall try to show how coöperation may function when the objectives and methods are reviewed together.

Coöperation in health protection

The first area of objectives was health protection. This includes:

The detection of disease
Exclusion of the suspected case and known contacts
Readmission of the case in accordance with established regulations.

Here, the physician should establish the steps to be followed, and should set up regulations. The physical education teacher complies in the same manner as other members of the faculty, perhaps more conscientiously because of certain conditions favoring the spread of communicable disease such as overcrowded locker and shower rooms, contaminated mats, and close contact between players in games. Where a change of clothes is practiced, the physical education teacher has the opportunity to detect skin diseases and infectious lesions not visible on the face or hands. During activities he should be alert to observe such symptoms as disinclination to play, undue fatigue, shortness of breath, blue lips, and limping. All such conditions should be reported. There should be special rules in time of epidemic, and instructions concerning their purpose and importance should be given by the physician or nurse.

Convalescents from illness, operation, or injury should be exempt from physical education until recovery is complete, the time varying with the condition. This should be an inflexible rule especially in case of rheumatism—regardless of degree—rheumatic fever, tonsillitis, and chorea, for these are important causes of heart disease. Conceivably the school physician may not know of these cases. It falls upon the nurse, therefore, to report them to both the physical education teacher and the physician.

There should be a standing order covering all such cases.

Finally, the physical education teacher is in an excellent position to support the health service department in its drive for immunization against smallpox and diphtheria.

In this hasty presentation we have touched upon these coöperative methods: reciprocal reporting, instructions, regulations, and standing orders.

Coöperation in health promotion

The second area of objectives we called health promotion. This covers the whole field of health education, including such phases as hygiene, physiology, first aid, sex education, narcotic education, nutrition, and such health habits as may be practiced with physical education.

Here, the physician, dentist, or nurse may help as follows:

Special talks and demonstrations

Furnishing facts and statistical data concerning health conditions in a given school or school district, this information to be used as the foundation of lesson planning and units of work

Providing reference books and lending professional publications such as periodicals and pamphlets.

Joining with the physical education teacher in petitioning the board of education for funds with which to establish a health education section in the school library, to purchase charts, models, and other teaching aids

Furnishing lists of sources of health information; contacting the national health organizations and science foundations

Talking to athletic squads on diets for conditioning, and for gaining or losing weight; on sleep, care of the teeth, and other health subjects.

In turn, the physical education teacher helps the health service department to the extent that he (or she) brings about desirable practices among the students in regard to diet and eating habits, sleep, visits to the dentist, body conditioning, and other essentials of healthful living. Eventually every school will have some kind of a light program and facilities for rest in order to care for the undernourished, the tired, and the nervous child, and similar cases.

Coöperation in prevention of injuries

The third group of objectives was called prevention of injuries. The physician can't prevent injuries by his attendance at games, but he can prevent them from becoming worse by insuring proper care. He can also assist with the observation of early symptoms of ill health, the detection of which is an important factor in preventing injuries. The color and sparkle of the eye, the tint of the skin and mucous membranes, and the appearance of the tongue are signs used daily by the physician, and in interpreting them he becomes adept. Frequently the first signs of staleness can be detected through trained observation.

Many physicians, especially surgeons or those who have participated in athletics, can give the coach valuable instruction in advanced first aid or in accident prevention by means of special taping and bandaging.

A common cause of injury in athletics is the poor condition of the field. Where this is true, the physical education teacher's best ally in a campaign for better facilities should be the school physician. By keeping a daily record of bruises, sprains, and other injuries, he can show statistically that a rough surface and stones are often to blame rather than the nature of the game or the tactics of players.

Coöperation in health appraisal

The fourth section was health appraisal. In health examinations the physical education teacher may coöperate in several ways, principally in the high school. It works particularly well in the examination of girls where the woman physical education teacher and the nurse are permitted to conduct the supplementary tests of vision, hearing, joint mobility, coördination, and foot measurement.

Coöperation here will come to be increasingly desirable because of the transition in physical education which is leading us to prescriptive programs for specific conditions and to homogeneous grouping. In working with the physician, the physical education teacher becomes better acquainted with the physical needs of his pupils than he could through observation alone.

I believe we shall gradually adopt the blood pressure test and urinalysis in the examination of athletes. It may be possible to enlist the aid of the chemistry department for the urinalysis, making the test a laboratory project for the members of the team who are enrolled for chemistry. Naturally, these will be screening tests only. Suspicious cases should be retested by the physician.

Another requirement which is gaining in favor is the tuberculin test. Physical education teachers can help materially through education and by insisting upon the test for athletic squads, thus providing statistics for the school and also setting an example.

Coöperation in corrective measures

The fifth area was that of corrective measures. The objectives here are obvious. They relate to:

Correction of all health defects, by making this an aim of physical education
Body mechanics
Prescription of special exercise or rest for cardiac cases, crippled children, the undernourished, and the anemic
Body building for the weak, flabby types who are otherwise healthy
Treatment and prevention of athlete's foot
Mild recreative programs for the physically under par and emotionally unstable child

The possibilities for coöperation are evident in the nature of the work, which involves, equally, medical and physical education training.

Coöperation in sanitation

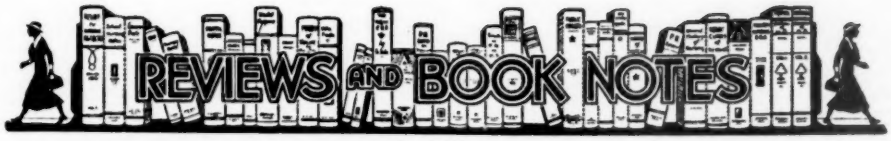
The last division was sanitation. To assist the physical education department, the physician can insist that proper locker, shower, and toilet facilities be provided, that a towel and soap supply system be introduced, and that towels be laundered in accordance with certain standards; that sanitation be practiced by janitors throughout the physical education plant; that pupils be required to have their costumes and team uniforms cleaned at frequent intervals; and that mats be cleaned periodically. Heating and ventilation, lighting, and swimming-pool sanitation should be standardized jointly by the two departments.

While I have mentioned the physician as the representative of health service, many of the examples apply equally well to the nurse. In fact, when a physical education teacher wants the aid and support of the physician he would do well in many instances to approach the nurse first, leaving the next step to her.

The list of coöperative activities is not inclusive. Minor points may be read between the lines. Eventually, too, I believe we shall coöperatively do more for the health and recreation of teachers. At many points it is obvious that a third party will have to be involved, such as the janitor, or perhaps other teachers especially concerned with health—for example, the home economics teacher. Of course the superintendent and the principals should be consulted in regard to all innovations.

Extensive coördination is rare at the present time. But like all new developments it must pass through the processes of evolution from which it will some day emerge in full blossom, both as an accepted principle and as a successful administrative procedure. Those who hold faith with me in this prediction may hasten that day by resolving now to be each year a little more coöperative than ever before—aye, a little more coöperative than are those with whom we coöperate.

ALLEN G. IRELAND, M.D.
Director, Health, Safety, and Physical Education, New Jersey State Department of Public Instruction, Trenton, New Jersey



EDITED BY
ELEANOR W. MUMFORD

BOARD MEMBERS' MANUAL

By the National Organization for Public Health Nursing. 162pp. The Macmillan Company, New York, second edition, 1937. $1.50.

This revision of the *Board Members' Manual* was prepared by a committee of six lay members and a director of a public health nursing agency, under the direction of the National Organization for Public Health Nursing. Dr. George E. Vincent, recent president of the Rockefeller Foundation, has written the preface. His opening sentence, "Public health nursing is not a thing apart," strikes the keynote of the book.

For an established nursing organization or a group about to organize a new nursing service, this manual should prove indispensable. Every phase of the question, from a suggested constitution and by-laws to personnel policies, is adequately handled.

There has been a complete revision to accord with the changing conditions in public health nursing, one of which is the increase in the number of public health nursing services under tax-supported agencies. Because of this trend the Manual has a chapter on "Promotion of Citizen Interest in Tax-Supported Services," which points out the definite responsibility of the public to the official nursing and health organizations, and shows that help can be given them in a well organized advisory and volunteer service.

The importance of having the complete and wholehearted coöperation of the medical profession is again stressed and a warning is sounded against the temptation to go ahead without the full understanding and support of local, state, and national medical groups.

A new chapter has been added on the many opportunities for volunteer service. These suggestions should prove stimulating, and while not always possible of attainment should serve as an ideal toward which to work.

Undoubtedly the part of the Manual which will be most helpful, both to the committee members and to the nurse director, is the chapter on "Personnel Policies." Should we not look to health agencies to lead the way in providing healthful working conditions? This chapter discusses such vital problems as the hours of duty, vacations, health examinations, and salaries, and suggests possible retirement plans.

The appendix, with its statement on incorporation and its suggested constitution and by-laws for a public health nursing organization as well as suggested advisory committee rules, brings the Manual to a fitting close.

The National Organization for Public Health Nursing is to be congratulated on producing such an attractive, well written, and completely useful manual for board members.

ANNA JONES MARIETTE
Member of the Board of Directors, Community Health Service of Minneapolis, Minneapolis, Minnesota

OTHER PUBLICATIONS OF INTEREST TO BOARD MEMBERS

LAY LEADERSHIP IN FAMILY SOCIAL WORK. Francis H. McLean. *The Family*, June 1937, p. 310.

WHAT ABOUT VOLUNTEERS. Florence Lukens Newbold. *Survey*, July 1937, p. 214.

A resumé of the work of the National Committee on Volunteers and a discussion of the important place of volunteers and social work.

GETTING READY TO BE A MOTHER

By Carolyn Van Blarcom. 305pp. The Macmillan Company, New York, third edition, 1937. $2.

Because this book is so widely used by mothers and public health nurses, we have asked Mrs. Joyce Daume, a committee member of the Detroit Visiting Nurse Association, to present the point of view of the mother, and Dorothy Holmes, a staff nurse of the same association, to present that of a public health nurse.

A Mother Speaks

The third edition of *Getting Ready to be a Mother* is an important guide for an expectant or new mother.

The book is divided into two parts, the first dealing with the mother, and her care of herself; the second, with the baby, and its care from birth to one year.

Part one points out that since a baby is really nine months old when it is born its care should start as soon as the mother knows she is pregnant. It stresses the value of the doctor's and dentist's care and the importance of following their advice, and gives simple rules for a happy, healthy pregnancy.

The chapters on the baby cover everything from the planning and making of baby clothes, furniture, and the preparation of food, to the actual schedules for and treatment of well babies as well as emergency treatment for sick ones. The suggestions on child training are comparable to those of any modern book on child psychology.*

There has been some reorganization and more complete annotation, making the book easier to use as a handbook. Except for the chapters on child training, new information on vitamins, and additional stress on diphtheria immunization, there is little change in the new edition. The only criticism is that the new type is smaller, and less easily read.

Finally, I consider the book a great aid to a mother's understanding and care of herself and of her baby, before and after he is born. It is cheerful, practical, and thorough. J. D.

A Staff Nurse Speaks

Miss Van Blarcom in the third edition of her book, *Getting Ready to be a Mother*, has changed the arrangement and added two chapters, "Training the Baby," and "The Baby in the World of Grown-ups," containing practical suggestions for the establishment of habit training and the adjustment of family life to include a new member.

The style is simple and easily understood by the average mother, and embodies the important principles of prenatal care. It stresses how much a mother can do for her baby by insuring good care of herself; the importance of early medical attention, a diet which adequately meets the needs of both mother and baby, cleanliness, adequate rest, moderate exercise, and a cheerful, serene state of mind. This is written in detail and serves as a home reference to emphasize the teaching of the physician.

The presentation, in the appendix, of symptoms of labor will be used by mothers as a means of determining the beginning of labor and the time to call the physician.

The book is applicable to home teaching with the exception of the chapter on home deliveries, which seems too elaborate. Many a mother being confined at home could not afford such an extensive list of supplies, nor would she have time during labor to make an elaborate set-up without the assistance of an experienced person. This chapter does not seem to agree with the modern trend in home teaching, which is to simplify techniques. D. H.

*Editor's Note: It is suggested that nurses supplement the material in this book on behavior problems such as thumb-sucking, masturbation, and ear-pulling by references dealing with the psychological aspects of these subjects. For example, *Children in the Family*, by Harold H. Anderson, published by D. Appleton-Century Company, New York, 1937. (Pages 130 ff.)

MATERNAL CARE

The Principles of Antepartum, Intrapartum and Postpartum Care for the Practitioner of Obstetrics.

By Dr. F. L. Adair, Editor. 93pp. University of Chicago Press, Chicago, 1937. $1.

The foreword of this pamphlet tells us that its purpose is to "set forth in simple and concise form some of the basic principles of maternal care." According to the foreword also, the book is written for physicians and nurses.

Actually the book itself presents the part of the physician in obstetrics. It includes the information necessary for intelligent care during the entire maternal cycle. Although the part of the nurse is not mentioned, it will be a handy reference for nurses on what to teach. To public health nurses the principal value of the book lies in its concise presentation of good obstetrical practice for the physician.

E.W.M.

RECENT PUBLICATIONS AND CURRENT PERIODICALS

PUBLICITY

INTERPRETERS. Mary Swain Routzahn. *Better Times*, December 7, 1936, p. 22.

An excellent article on interpretation and on the most important form of publicity.

BIBLIOGRAPHY ON SOCIAL WORK INTERPRETATION. Prepared by Mary Swain Routzahn. Russell Sage Foundation, 130 East 22 Street, New York, N. Y., 1937. 10c.

THE PLAY AND SOCIAL WORK. Discussed by Viola Paradise and Clarence A. Perry. The Social Work Publicity Council, 130 East 22 Street, New York, N. Y., September 1936. 25c.

"I SEE BY THE PAPERS . . ." Prepared by Newspaper Survey Committee, Social Work Publicity Council Chicago Chapter, 203 North Wabash Avenue, Chicago, Ill. 60pp.

This is a survey of social welfare news found in the Chicago daily papers, a total of some 5000 clippings collected by sampling the entire field for four months out of the year. This type of study would seem to be an excellent index of reader interest, a sense of which is essential to planning newspaper publicity.

HEALTH EDUCATION OF THE PUBLIC. W. W. Bauer, M.D., and Thomas G. Hull, Ph.D. W. B. Saunders Company, Philadelphia, 1937. $2.50.

This book is an excellent reference on mass health education methods and principles. The definitions, objectives, and sources of material are equally applicable to health education on an individual or family basis. Public health nurses, especially those who do group work on an occasional project such as an exhibit, radio talk, or preparation of pamphlet will find this book very useful.

1000 AND ONE. The Blue Book of Non-theatrical Films. The Educational Screen, 64 East Lake Street, Chicago, Ill., twelfth edition 1936-37. 152pp. 75c.

A STUDY OF AGENCY MEMBERS AS A BASIS FOR INTERPRETATION. Perry B. Hall. *The Family*, July 1937, p. 170.

An analysis of the membership of a particular agency as a basis for planning a program of interpretation to the members so that they in turn may fulfill responsibilities as interpreters.

STAFF EDUCATION AND SUPERVISION

THE SUPERVISING NURSE. J. Rosslyn Earp, Dr.P.H. *American Journal of Public Health*, August 1937, p. 817.

Dr. Earp points out to health officers that there need be no conflict between supervisor and administrator in official agencies.

SOME EMOTIONAL ELEMENTS IN SUPERVISION. Report of a Group Discussion. Family Welfare Association of America, 130 East 22 Street, New York, N. Y., 22pp. 25c.

Three papers based upon the minutes of discussions by social case workers and supervisors of the role of the supervisor in assisting the student to orient himself to other people and to himself. Applicable in equal degree to public health nursing.

HOW TO HAVE GOOD BULLETIN BOARDS. Gladys M. Stilson. BULLETIN BOARDS IN THE HOSPITAL. Henrietta Davis. *American Journal of Nursing*, July 1937, pp. 719-724.

The two articles offer suggestions for the effective use of bulletin boards in student and staff education.

SUPERVISION IN PUBLIC HEALTH NURSING. Alice Ahern. *Canadian Public Health Journal*, March 1937, pp. 125-127.

A simple, clear statement of supervision in public health nursing, its value, functions, and methods.

Correction. The price of the outlines on maternity care from the Maternity Center Division of the Visiting Nurse Association of Brooklyn, listed in the October issue, should be 45 cents.

• Dr. William Freeman Snow, general director of the American Social Hygiene Association, was honored on October 1 at a dinner in New York City, given by a committee of friends and admirers who have known or been associated with Dr. Snow during his career of 40 years in social hygiene and public health work, both in the United States and abroad. Over 400 guests attended the dinner, during which congratulatory messages were received from all parts of the country as well as Europe.

• American Education Week, sponsored jointly by the National Education Association, the United States Office of Education, and the American Legion, will be observed November 7-13. The aim of the observance is to enable almost 10,000,000 parents to know more about what their country's schools are doing and why.

• Newly elected officers of the Oregon State Organization for Public Health Nursing are: Jean Gallien, President, Amy Erickson and Clara Engebretsen, 1st and 2nd Vice-President respectively, Ruth Fletcher, Secretary, Vera Wallace, Treasurer, Mae Dwyer and Nettie Alley, Nurse Directors, and Dr. Helen Cary and Dr. Jessie L. Brodie as Lay Directors.

• The annual New Jersey Health Education Meeting for School Nurses and the regular meeting of the School Nurses' Section of the State Organization for Public Health Nursing will be held at the Ritz-Carlton Hotel, Atlantic City, N. J., November 12 and 13. The afternoon of the first day is devoted to a joint session with the New Jersey Physical Education Association, and the afternoon of the second day to a joint luncheon with the Association.

• The Vermont State Nurses' Association met at Rutland City Hospital, Rutland, Vermont on October 28, 1937. There were sectional meetings for public health and private duty nurses. Mr. Thomas Mangan of Rutland spoke on "The Problems of Our Dependent and Delinquent Children" and Dr. B. F. Cook addressed the meeting on "Non-tuberculous Diseases of the Chest."

• A series of fourteen regional round table conferences for professional workers on education in family life and parenthood are being held during the period from October 20 to January 28 in various cities throughout the country.

Teachers of children and young people, adult education leaders, counselors, administrators, and other professional workers will meet in each city, with representatives of the governing board and staff of the National Council of Parent Education, to examine and evaluate the family and parent education work in which they are engaged. Information about these conferences may be secured from the National Council of Parent Education, 60 East 42 Street, New York, N. Y.

• Mrs. Peter L. Harvie, President of the Association of the Junior Leagues of America, has asked all Junior Leagues to appoint delegates to the Welfare Conference to be held in Milwaukee, Wis., November 1 to 5. It will be the third of a series of conferences initiated by the Association a few years ago to provide professional guidance and technical information to delegates interested in various phases of social welfare. The

program will consist of lectures and discussions, field trips, and consultation service.

• The Minnesota State Department of Health, through the Division of Child Hygiene, is conducting their third annual nursing education series under the name, "Public Health Nurses' Refresher Course." The subject matter is on eye hygiene, nutrition, and dental health. The meetings will be held in Bemidji, Duluth, Mankato, Minneapolis, St. Cloud, and Winona.

• At the annual meeting of the Association of Women in Public Health held at the Hotel McAlpin, New York, N. Y., October 7, Sally Lucas Jean, Executive Secretary of the Health Section of the World Federation of Education Associations, was elected to succeed Dr. Mary L. Lakeman as president of this national group of health workers in the fields of public health, medicine, nursing, bacteriology, chemistry, statistics, and health education.

• Radio programs on the Mobilization for Human Needs this year will be interwoven in many of the regular programs of the various networks. These will continue till November 15. For information on hours and stations inquire of your local Community Chest.

• The National Association of Colored Graduate Nurses has reëlected Mrs. Estelle M. Riddle of Akron, Ohio, as its President. Other officers elected were Mrs. Frances Gaines, Chicago, Ill., and Mary Sales, Indianapolis, Ind., 1st and 2nd Vice-Presidents, Mrs. Bessie Parker Evans, Kansas City, Mo., Recording Secretary,; Mrs. Eliza Pillars, Jackson, Miss., Financial Secretary; and Petra Pinn, New York, N. Y., as Treasurer. A field secretary is to be added to the personnel of the organization, to help local and state organizations with their problems. The 1938 meeting will be held at Hampton Institute, jointly with the National Medical Association and the National Hospital Association.

• A separate building has been assigned by the New York World's Fair of 1939 for the presentation of the story of medicine and public health. The exhibits for this building are being planned by a General Advisory Committee, composed of 101 national, state, and local authorities on medicine and public health. Dr. Victor Heiser is chairman of the committee. This building will give a complete picture of man in his totality, together with the many hazards that menace him, each shown in its relationship to man and to one another.

The building will be divided into three main chambers to be designated as The Hall of Man, The Hall of Medical Science, and The Hall of Public Health. It is planned that the Hall of Public Health will emphasize the health problems of society, how they are being met, and how they relate to the individual. Some of the proposed sections are maternal health, infant and child hygiene, heredity and eugenics, mental hygiene, industrial hygiene, safety and first aid, sewage disposal and water supply, intestinal diseases such as typhoid fever and dysentery, the control of communicable diseases, school hygiene, deafness, and blindness.

NEW APPOINTMENTS

(*For J.V.S. Appointments see page 663*)

Bertha Allwardt, American Red Cross Nursing Field Representative, State of New York.

Cecilia Walsh, American Red Cross Nursing Field Representative, States of Maine and New Hampshire.

Carrie Nelson, Director, Central Bergen Visiting Nurse Service, Hackensack, N. J.

Grace W. Beatty, State Consultant Nurse for Southern Area, Indiana State Board of Health, Indianapolis, Ind.

Beata L. Karnath, Hygienist, Public Schools, Kansas City, Mo.

Dorothy Campbell, Director of Health and Welfare, Cook County Hospital, Chicago, Ill.

Hedwig Toelle, Instructor of Public Health Nursing, Yale University School of Nursing, New Haven, Conn.

Study Page for November

Suggestions for Board Members, Executives, Staff Nurses, and Students

The following questions are based on the published material in this number, and offer suggestions for the use of the magazine:

Board Members

What does the latest census of public health nurses show regarding the total number in the United States today? *Census of Public Health Nurses 1937.* Page 648.

How can the modern board member become informed regarding his job? *The New Board Members' Manual.* Page 615.

In what areas of public health work can the greatest saving of life be brought about? *Public Health Nursing Marches On.* Page 617.

What qualifications are needed to be an effective board member today? *The Modern Board Member.* Page 629.

Executives and Supervisors

What are some methods by which a pneumonia staff program can be carried on? *A Program for Staff Education—Pneumonia.* Page 653.

What are the responsibilities of a board member today? See question 4 under Board Members.

What challenges does the Surgeon General of the U. S. Public Health Service offer to public health nursing? See question 3 under Board Members.

How does Wisconsin coördinate the care and education of its crippled children? *Wisconsin's Dual Program for the Crippled Child.* Page 642.

Staff Nurses

How did the National Organization for Public Health Nursing get its name? *I Christen Thee.* Page 640.

What information about the work of a medical unit should be included in its report to management? *The Medical Unit Reports to Management.* Page 634.

How can the nurse help parents with problems of habit formation? *Habit Training During the Preschool Years.* Page 623.

Can you answer these questions about maternity nursing? *How Would You Answer These?* Page 641. About pneumonia care? See question 2 under Executives and Supervisors.

Student Nurses

What should a nurse know about the prevention and treatment of pneumonia? See question 2 under Executives and Supervisors.

How Would You Answer These questions on maternity nursing? Page 641.

What are some types of habit training in children, with which parents may need help and suggestions? See question 3 under Staff Nurses.

Name some aspects of nursing education, in relation to public health problems, that were discussed at the International Congress of Nurses. *An English Nurse Describes the I.C.N.* Page 645.

Our query, "A Study Page—Yes or No?" in September has brought responses from many subscribers, who ask that it be resumed. We will therefore publish it hereafter whenever our space permits.

(Continued from page 660)

historical pageant presented at a luncheon, by the New York Public Health Association, showing milestones in the history of the public health movement in the United States. Casting and costuming were done largely by the New York WPA, and the very talented cast was drawn from the New York City Department of Health. Dr. Haven Emerson gave a short explanatory talk before each scene. In the episode depicting Lillian D. Wald and Mary M. Brewster receiving the first contribution to the Henry Street Settlement from Jacob H. Schiff, Dr. Emerson paid special tribute to the place public health nursing plays in modern public health activities.

These are some highlights selected for special mention, out of many interesting and worthwhile meetings. It is hoped that part or all of the prepared papers which are referred to above will appear in print.

(Continued from page 663)

Mrs. Sara P. Sheffler, Community Nurse, Deep River Public Health Nursing Association, Deep River, Conn.

Elaine Almen, School Nurse, Le Mars Public Schools, Le Mars, Iowa.

Myrtle Haase, School Nurse, Powell Public Schools, Powell, Wyo.

Frances Iler, Resident School Nurse, Scarborough School, Scarborough, N. Y.

Mrs. Anne N. Clegg, Temporary Industrial Nurse, Horn & Hardart Restaurants Clinic, New York, N. Y.

Mrs. Mary J. Gomes, Temporary Nurse, Wave Crest Convalescent Home, Far Rockaway, N. Y.

Mrs. Mildred Baylor, Camp Nurse, Robin Hood Camp, Palisades Interstate Park, N. J.

Daisy May Connor, Resident Nurse, Orphans' Home and Asylum of Protestant Episcopal Church, New York, N. Y.

Mrs. Mabel Shepard Beebe, Medical Social Worker, Bellevue Hospital, New York, N. Y.

To staff positions:

Rowena Darling, Visiting Nurse Association, Bridgeport, Conn.

Elinor Bull, Community Health Association, Boston, Mass.